THIRD AMENDED AND RESTATED

MASSHEALTH MANAGED CARE ORGANIZATION CONTRACT

BY AND BETWEEN

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

BOSTON MEDICAL CENTER HEALTH PLAN, INC.

This Third Amended and Restated Contract is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS") and Boston Medical Center Health Plan, Inc. (the "Contractor"), with principal offices located at 529 Main St., Ste. 500, Charlestown, MA, 02129.

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

WHEREAS, EOHHS issued a Request for Responses (RFR) on December 21, 2016, to solicit responses from managed care organizations (MCOs) to provide comprehensive health care coverage to MassHealth Members; and

WHEREAS, EOHHS has selected the Contractor, based on the Contractor's response to the RFR submitted by the deadline for responses to provide health care coverage to MassHealth Members in the Regions identified in **Appendix F**; and

WHEREAS, EOHHS and the Contractor entered into the Contract effective October 2, 2017, and with an Operational Start Date of March 1, 2018, to make available high quality, coordinated, comprehensive health care services on a capitated basis to specific eligible groups; and

WHEREAS, EOHHS and the Contractor amended and restated the Contract effective January 1, 2019, with various amendments thereafter (First Amended and Restated);

WHEREAS, EOHHS and the Contractor amended and restated the Contract effective January 1, 2020, with various amendments thereafter (Second Amended and Restated);

WHEREAS, in accordance with **Section 5.8** of the Contract, EOHHS and the Contractor desire to amend and restate the Contract effective January 1, 2021; and

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

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

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APPENDICES

SECTION 1. DEFINITIONS OF TERMS

The following terms or their abbreviations, when capitalized in this Contract and its Appendices, are defined as follows, unless the context clearly indicates otherwise.

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.

Accountable Care Partnership Plan – Accountable Care Organizations contracted with EOHHS as Accountable Care Partnership Plans

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

Actuarially Sound Capitation Rates – capitation rates that, as described in 42 CFR 438.4, have been developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations to be covered and the services to be furnished under the contract, have been certified as meeting the requirements of 42 CFR 438.4 by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board, and have been approved by CMS.

Adjustment – a compromise between the Contractor and the Enrollee reached at any time after an Adverse Action but before the Board of Hearings (BOH) issues a decision on a BOH Appeal.

Administratively Necessary Day – a day of Acute Inpatient Hospitalization on which an Enrollee's care needs can be provided in a setting other than an Acute Inpatient Hospital and on which an Enrollee is clinically ready for discharge, but for whom an appropriate setting is not available.

Administrative Services – the performance of services or functions necessary for the management of, the delivery of, and payment for, MCO Covered Services, and the coordination of Non-MCO Covered Services, including but not limited to network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems (MIS) operation and reporting, and state agency service coordination, including behavioral health.

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.

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

(1) the failure to provide MCO Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.9.B**;

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

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

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

i. failure to follow prior authorization procedures;

ii. failure to follow referral rules;

iii. failure to file a timely claim;

(5) the failure to act within the timeframes in **Section 2.6.C.5** for making authorization decisions; and

(6) the failure to act within the timeframes in **Section 2.12.B.4** for reviewing an Internal Appeal and issuing a decision.

All Patients Refined Diagnosis Related Group (APR-DRG) – the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper, Version 33, unless otherwise specified.

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

Alternative Payment Methodologies (APMs) – As further specified by EOHHS, methods of payment, not based on traditional fee-for-service methodologies, that compensate providers for the provision of health care or support services and tie payments to providers to quality of care and outcomes. These include but are not limited to shared savings and shared risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and global payments. Payments based on traditional Fee-For-Service methodologies shall not be considered Alternative Payment Methodologies.

American Sign Language (ASL) Interpreters – a communication access accommodation required by a deaf, or hard-of-hearing, or deaf blind person.

Appeals Coordinator – a staff person designated by the Contractor to act as a liaison between the Contractor and the BOH.

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, Internal Appeal, or BOH Appeal. The Contractor must allow an Enrollee to give a standing authorization to an Appeal Representative to act on his/her behalf for all aspects of Grievances and Internal Appeals. Such standing authorization must be done in writing according to the Contractor's procedures, and may be revoked by the Enrollee at any time. When a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the

denial of such treatment without parental/guardian consent and appoint an Appeal Representative without the consent of a parent or guardian.

Approved ACO Agreement - a contract between the Contractor and an MCO-Administered ACO approved by EOHHS that delineates responsibilities and establishes financial accountability as described in **Section 2.21.**

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.

Base Capitation Rate – a per Member per Month fixed fee for each Enrollee based on a defined set of MCO Covered Services, before adjustment, in accordance with the provisions of this Contract. The Base Capitation Rate shall be comprised of a Medical Component and Administrative Component.

BH – Behavioral Health. See Behavioral Health Services.

BH CP – Behavioral Health Community Partner

Behavioral Health Advisory Council (BHAC) – A recurring meeting convened and chaired by EOHHS that includes representatives of each MassHealth-contracted MCO, as well as stakeholders from state agencies, the provider community, Members, and, family advocates. The BHAC provides a forum in which to address behavioral health Contract deliverables, policies, directives and practice enhancements, and to identify opportunities for quality improvement.

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

Behavioral Health Diversionary Services – those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement (see **Appendix C**, as applicable) , or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those services which are provided in a 24-hour facility, and those services which are provided in a non-24-hour setting or facility.

- **24-Hour Diversionary Services** – those Diversionary Services that are provided in 24-hour placement settings other than an Inpatient Service (see **Appendix C**, as applicable), provided as clinically appropriate alternatives to these inpatient covered services.

- **Non-24-Hour Diversionary Services** – those Diversionary Services that are provided in community settings, such as the home, school, mental health center or substance use disorder clinic, or hospital

outpatient department, provided as clinically appropriate alternatives to 24-hour acute treatment (Inpatient Services, Community Based Acute Treatment (CBAT), Intensive Community Based Acute Treatment (ICBAT) or Community Crisis Stabilization (CCS)), or to support an Enrollee returning to the community following an Inpatient Services discharge, or that provide intensive support to maintain functioning in the community.

Behavioral Health Services (or BH Services) – mental health and substance use disorder services that are MCO Covered Services set forth in detail in **Appendix C** , as applicable, of this Contract.

Behavioral Health Inpatient Services – mental health or substance use disorder services, or both, set forth in **Appendix C,** as applicable, of the Contract, which are provided in a twenty-four hour setting, such as a hospital.

Behavioral Health Outpatient Services – mental health and substance use disorder services set forth in **Appendix C**, as applicable, of the Contract, which are provided in an ambulatory care setting, such as a mental health or substance use clinic, hospital outpatient department, community mental health center, or Provider's office.

Benefit Coordination – the function of coordinating benefit payments from other payers, for services delivered to an Enrollee, when such Enrollee is covered by another insurer.

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

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

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), the EOHHS Office of Medicaid and the Department of Children and Families (DCF).

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

CANS IT System – a web-based application accessible through the EOHHS Virtual Gateway into which Behavioral Health Providers serving Members under the age of 21 will input: (1) the information gathered using the CANS Tool; and (2) the determination whether the assessed Member has a Serious Emotional Disturbance.

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

Coordinator may serve on one or more care teams, coordinates and facilitates meetings and other activities of those care teams.

Care Management – the provision of person-centered, coordinated activities to support Enrollees' goals as described in **Section 2.5.E** of this Contract:

Care Needs Screening – a screening to identify an Enrollee's care needs and other characteristics as described in **Section 2.5.B**.

Care Plan – the plan of care developed by the Enrollee and other individuals involved in the Enrollees care or Care Management, as described in **Section 2.5.D.2**, inclusive of Person-Centered Treatment Plans developed by BH CPs**.**

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

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

Child and Adolescent Needs and Strengths (CANS) Tool – a tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Mental Health Services and Community Based Acute Treatment Services as described in **Appendix C**. A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health Providers serving Enrollees under the age of 21.

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

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

CBHI Services Medical Necessity Criteria – the criteria used to determine the amount, duration or scope of services to ensure the provision of Covered Services that are Medically Necessary.

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.

Claim Attachment – a supplemental document submitted in conjunction with a Claim, that provides additional information that concurs with the services billed.

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.

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

Clinical Criteria – criteria used to determine the most clinically appropriate and necessary level of care and intensity of services to ensure the provision of Medically Necessary services.

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

Communication Access Realtime Translation (CART) – a communication access accommodation required by a deaf or hard-of-hearing person. CART involves word for word instant translation of what is being said into visual point display so that it can be read instead of heard.

Community Partners (CPs) – entities certified by EOHHS to work with ACOs to ensure integration of care, as further specified by EOHHS. There are two types of CPs – Long-Term Services and Supports CPs (LTSS CPs) and Behavioral Health CPs (BH CPs).

Community Partner Assigned Enrollee – An Enrollee who is assigned to a BH or LTSS CP (BH CP-Assigned Enrollee and LTSS CP-Assigned Enrollee, respectively).

Community Partner Documented Processes - written documents approved by all parties to the ACO/MCO-CP Agreement that outline the steps necessary to complete a task or function, as described in **Appendices U** and **V**.

Community Partner Engaged Enrollee –

- BH CP-Engaged Enrollee – A BH CP-Assigned Enrollee for whom the BH CP has completed a Comprehensive Assessment and person-centered treatment plan, and the person-centered treatment plan has been signed or otherwise approved by the BH CP-Assigned Enrollee (or legal authorized representative, as appropriate) and approved and signed by the BH CP-Assigned Enrollee's PCP or PCP Designee.
- LTSS CP-Engaged Enrollee – An LTSS CP-Assigned Enrollee for whom the LTSS CP has completed the LTSS component of the LTSS CP-Assigned Enrollee's Care Plan, and the LTSS component of the LTSS CP-Assigned Enrollee's Care Plan has been signed or otherwise approved by the Enrollee (or legal

authorized representative, as appropriate) and approved and signed by the LTSS CP-Assigned Enrollee's PCP or PCP Designee.

Community Partner Identified Enrollee – An Enrollee who is identified by EOHHS for assignment to a BH or LTSS CP (BH CP-Identified Enrollee and LTSS CP-Identified Enrollee, respectively).

Community Partners Operational Start Date -- the date on which CPs start to provide CP supports as determined by EOHHS. The CP Operational Start Date is July 1, 2019.

Community Partner Referred Enrollee – An Enrollee who is recommended for BH or LTSS CP supports by the Enrollee, a PCP, provider, or others as further specified by EOHHS (BH CP-Referred Enrollee and LTSS CP-Referred Enrollee, respectively).

Comprehensive Assessment – a person-centered assessment of an Enrollee's care needs, functional needs, accessibility needs, goals, and other characteristics, as described in **Section 2.5.D.1.**

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

Contract – the Contract between EOHHS and the Contractor awarded pursuant to the RFR.

Contract Effective Date – The date on which the Contract is effective, which shall be the date this Contract is fully executed by both parties.

Contract Operational Start Date (Operational Start Date) – the date on which the Contractor starts to provide MCO Covered Services to Enrollees, March 1, 2018.

Contract Year (CY) – For Contract Year 1, a ten-month period commencing March 1, 2018 and ending December 31, 2018, unless otherwise specified by EOHHS. For other Contract Years, a twelve-month period commencing January 1 and ending December 31, unless otherwise specified by EOHHS.

Contractor – any entity that enters into an agreement with EOHHS for the provision of services described in the Contract.

Contractor's Plan (or Plan) – the managed care program administered by the Contractor pursuant to the Contract.

Co-Morbid Disorders – the simultaneous manifestation of a physical disorder and a behavioral health disorder, or two different physical health disorders.

Co-Occurring Disorders (or Dual Diagnoses) – medical conditions involving the simultaneous manifestation of a mental health disorder and a substance use disorder.

Coverage Type – a scope of medical services, other benefits, or both, that are available to members who meet specific MassHealth eligibility criteria. EOHHS's current Coverage Types with Members who may be enrolled

with the Contractor are: Standard, Family Assistance, CarePlus and CommonHealth. See 130 CMR 450.105 for an explanation of each Coverage Type.

Credentialing Criteria – criteria establishing the qualifications of Network Providers. See **Section 2.8.H.** of this Contract.

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

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

Customer Service Center (CSC) Enrollment Vendor – EOHHS's enrollment broker that provides Members with a single point of access to a wide range of customer services, including enrolling Members into ACOs, MassHealth-contracted MCOs and the PCC Plan, authorizing non-emergency transportation services, and providing Members with information about Non-MCO Covered Services.

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

DCF – the Massachusetts Department of Children and Families.

DDS – the Massachusetts Department of Developmental Services

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

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

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

DMH – the Massachusetts Department of Mental Health.

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

DMH Case Manager – the individual responsible for implementing DMH Case Management Services.

DMH Client – an Enrollee who DMH has determined is eligible for DMH Community-Based Services according to DMH Clinical Criteria.

DMH Community-Based Services – DMH non-acute mental health care services, provided to DMH Clients, such as community aftercare, housing and support services, and non-acute residential services.

DPH – the Massachusetts Department of Public Health.

Drug Rebate (Medicaid Drug Rebate Program) – a program authorized by Section 1927 of the Social Security Act involving CMS, state Medicaid agencies, and approximately 600 participating drug manufacturers that helps to offset the federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.

Drug and Non-Drug Pharmacy Product Rebate Data – a dataset provided by the Contractor related to the Drug Rebate and Non-Drug Pharmacy Product rebates. As further specified by EOHHS, Drug and Non-Drug Pharmacy Product Rebate Data shall include pharmacy claims data, 837 medication claims data, pharmacy Provider Network data, and the MassHealth Rebate File Submission Reports (see **Appendix A**).

Dually Eligible – individuals determined eligible for both Medicaid and Medicare.

DYS – the Massachusetts Department of Youth Services.

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

Early Intervention Provider – a provider licensed and/or certified by the Massachusetts Department of Public Health to provide Early Intervention Services.

Early Intervention Services – a comprehensive program for children between the ages of birth and three years whose developmental patterns are atypical, or are at serious risk to become atypical through the influence of certain biological or environmental factors. Early Intervention Services include a set of integrated community-based developmental services which use a family centered approach to facilitate developmental progress. Early Intervention Program regulations are found at 130 CMR 440.000.

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

Effective Date of Disenrollment – up to 11:59 p.m. on the last day, as determined by EOHHS, on which the Contractor is responsible for providing MCO Covered Services to an Enrollee and as reflected in the HIPAA 834 Outbound Enrollment File.

Eligibility Verification System (EVS) [formerly known as the Recipient Eligibility Verification System (REVS)] – the online and telephonic system Providers must access to verify eligibility, managed care enrollment, and available third party liability information about Members.

Emergency Aid to the Elderly, Disabled, and Children (EAEDC) – a cash assistance program administered by the Massachusetts Department of Transitional Assistance. Individuals receiving EAEDC cash assistance are eligible for MassHealth Basic coverage upon Managed Care enrollment in accordance with the requirements of 130 CMR 508.000. Families receiving EAEDC are eligible for MassHealth Standard coverage.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of an Enrollee or another person or, in the case of a pregnant individual, the health of the individual or their unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant individual, as further defined in Section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

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 Title XIX of the Social Security Act, and are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

Emergency Services Programs (ESPs) – Medically necessary services provided through designated, contracted providers, and which are available seven (7) days per week, twenty-four (24) hours per day to provide treatment of any individual who is experiencing a mental health or substance use disorder crisis, or both. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization, as described in **Appendix C**. In addition to contracted ESPs, ESP Encounter services (not Youth Mobile Crisis Intervention services) may also be provided by outpatient hospital emergency departments as further directed by EOHHS.

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 E**.

Enrollee – a Member enrolled in the Contractor's Plan, either by choice, or assignment by EOHHS. 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.

Enrollee Days – the sum of the number of days each Enrollee is enrolled in the Contractor's Plan.

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

Enrollee Information – information about a Managed Care Organization (MCO) for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.7.E**., and an Enrollee handbook that contains all of the information in **Section 2.4.B.2.f**.

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

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

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

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

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

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

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

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

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

D. Are at high risk of institutionalization;

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

F. Are chronically homeless;

G. Are at high risk of inpatient admission or Emergency Department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting; or

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

EPSDT Periodicity Schedule (or Schedule) – the EPSDT Medical Protocol and Periodicity Schedule that appears in Appendix W of all MassHealth provider manuals and is periodically updated by EOHHS in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts Department of Public

Health, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Estimated Capitation Payment (ECP) – a prospective monthly payment made by EOHHS to the Contractor based on an estimation of the number of Member months multiplied by the applicable Per Member Per Month Capitation Rate.

Exchange – the Commonwealth Health Insurance Connector Authority (Health Connector), Massachusetts' affordable insurance exchange in accordance with the Patient Protection and Affordable Care Act that serves as a competitive marketplace for purchasing insurance coverage.

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 and Titles XIX and XXI of the Social Security Act, the § 1115 Medicaid Research and Demonstration Waiver and other applicable laws and waivers.

Experimental Treatment – services for which there is insufficient authoritative evidence that such service is 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.

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

External Quality Review Organization (EQRO) – the entity with which EOHHS contracts to perform External Quality Review Activities (EQR Activities), in accordance with 42 CFR 438.350 et seq.

Federal Poverty Level (FPL) – income standards that vary by family size, issued annually in the Federal Register to account for the preceding calendar year's increase in prices as measured by the Consumer Price Index (CPI).

Federally-Qualified Health Center (FQHC) – an entity that has been determined by the Centers for Medicare and Medicaid Services (CMS) to satisfy the criteria set forth in 42 USC 1396d(1)(2)(B).

Fee-for-Service (FFS) – a method of paying an established fee for any Non-MCO Covered Service to Enrollees, in accordance with EOHHS's applicable program regulations and service limitations.

Final Internal Appeal – the Contractor's final review of an expedited or standard Internal Appeal Decision.

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 himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of provider fraud include: lack of referrals by PCPs to specialists, 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.

Grievance – any expression of dissatisfaction 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.

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

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

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

Health 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.

Hepatitis C Virus Drugs (HCV Drugs) – Direct-acting antiviral (DAA) single and combination drugs as further specified by EOHHS

Incentive Payment Arrangement – any payment mechanism under which the Contractor may receive additional funds, over and above the Capitation Rates paid, for meeting targets specified in the Contract. See 42 CFR 438.6.

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

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

Internal Appeal – a request by an Enrollee or the Enrollee's Appeal Representative made to the Contractor for review of an Adverse Action.

Inquiry – any oral or written question by an Enrollee to the Contractor's Enrollee services department regarding an aspect of Contractor operations that does not express dissatisfaction about the Contractor.

Key Contact – Member of Contractor's staff who liaises with EOHHS and serves as a point of contact for EOHHS for all communications and requests related to this Contract.

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

LTSS CP – Long-Term Services and Supports Community Partner

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

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

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

Massachusetts Health Information Highway (Mass HIway) – Massachusetts' statewide electronic health information exchange.

Massachusetts Health Quality Partners (MHQP) – a broad-based coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in the quality of health care services in Massachusetts.

MassHealth – the medical assistance or benefit programs administered by EOHHS.

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

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

MassHealth DRG Weight – The MassHealth relative weight developed by EOHHS for each unique combination of All Patient Refined Diagnosis Related Group and severity of illness (SOI).

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

MassHealth Managed Care Program – all MassHealth Managed Care Organization (MCO) Plans, Accountable Care Partnership Plans, other MassHealth-contracted accountable care organizations, and the Primary Care Clinician (PCC) Plan that serve all managed care eligible Members under age 65.

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

Material Subcontractor – any entity from which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of its Administrative Services for any program area or function that relates to the delivery or payment of MCO Covered Services including, but not limited to, behavioral health, claims processing, Care Management, Utilization Management or pharmacy benefits, including specialty pharmacy providers.

MCO Administered ACO – accountable care organizations contracted with EOHHS as MCO-Administered ACOs

MCO Covered Services – those services which are required to be provided by the Contractor as specified in **Appendix C** of the Contract. Such covered services shall not include any items or services for which payment is prohibited 42 USC 1396b(i)(17).

MCO/ACO - CP Agreement – a written agreement between the Contractor and a Community Partner that delineates roles and responsibilities, as described in **Appendix U** and **Appendix V.**

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

Medicaid Fraud Division (MFD) – a division of the Massachusetts Office of the Attorney General that is dedicated to investigating cases of suspected Provider Fraud or Abuse.

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

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

be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Medication for Addiction Treatment (MAT) Services – The use of FDA approved medications for the treatment of substance use disorders.

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

Mobile Crisis Intervention (MCI) (also referred to as Youth Mobile Crisis Intervention) – As set forth in Appendix C, Youth Mobile Crisis Intervention services include a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.

Network Management – refers to 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 Contractor MCO Covered Services.

Network Provider or Provider – an appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any subcontractor, for the delivery of services covered under the Contract.

New Enrollee – any Enrollee enrolled by EOHHS pursuant to **Section 2.4** who has not been previously enrolled in the Contractor's Plan within the preceding 12 months, or within another timeframe as determined by EOHHS.

Non-Drug Pharmacy Product – non-drug pharmacy products supplied through the Pharmacy MCO Covered Service set forth in **Appendix C**.

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

Non-MCO Covered Services – those services specified in **Appendix C** of the Contract which are coordinated by the Contractor, but are provided by EOHHS on an FFS basis.

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

Non-Symptomatic Care – an Enrollee encounter with a Provider that is not associated with any presenting medical signs. Examples include well-child visits and annual adult physical examinations.

Non-Urgent Symptomatic Care – an Enrollee encounter with a Provider that is associated with presenting medical signs and symptoms, but that does not require urgent or immediate medical attention.

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

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

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

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

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

The Patient Protection and Affordable Care Act (ACA or PPACA) – the comprehensive federal health care reform statute signed into law, as amended from time to time

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

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

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

Physical Health Services – all medical services other than Behavioral Health Services.

Poststabilization Care Services – MCO 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.

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

Preferred Drugs and Non-Drug Pharmacy Products – those drugs and Non-Drug Products for which MassHealth has entered into a supplemental rebate agreement for drugs or a rebate agreement for Non-Drug Pharmacy Products, or that MassHealth otherwise designates as preferred based on net costs to MassHealth, allowing MassHealth the ability to provide coverage of medications and Non-Drug Pharmacy Products at the lowest possible costs.

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

Primary Care – the provision of coordinated, comprehensive medical services, on both a first contact and a continuous basis, to an Enrollee. The provision of Primary Care incorporates an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

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

Primary Care Provider (PCP) – the individual Primary Care Provider or team selected by the Enrollee, or assigned to the Enrollee by the Contractor, to provide and coordinate all of the Enrollee's health care needs and to initiate and monitor referrals for specialty services when required. PCPs include nurse practitioners practicing in collaboration with a physician under Massachusetts General Laws Chapter 112, Section 80B and its implementing regulations or physicians who are board certified or eligible for certification in one of the following specialties: Family Practice, Internal Medicine, General Practice, Adolescent and Pediatric Medicine, or Obstetrics/Gynecology. 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.

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

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

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

Provider Contract (or Provider Agreement) – an agreement between the Contractor and a Provider for the provision of services under the Contract.

Provider Network – the collective group of Network Providers who have entered into Provider Contracts with the Contractor for the delivery of MCO Covered Services. This includes, but is not limited to, physical, behavioral, pharmacy, and ancillary service providers.

Provider Performance Incentive – any payment or other compensation granted to, or withheld from, a Provider as a result of engagement, or lack of engagement, in a targeted behavior, such as compliance with guidelines and other Quality Improvement initiatives, in accordance with **Section 5.1.H** and **Section 2.13.D.** All Provider Performance Incentives must comply with the requirements of Physician Incentive Plans as described in **Section 5.1.H** of this Contract.

Provider Preventable Conditions (PPC) – As identified by EOHHS through bulletins or other written statements policy, which may be amended at any 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).

Provider Site Marketing – any activities occurring at or originating from a Provider site, whereby Contractor staff or designees, including physicians and office staff, personally present Contractor Marketing Materials or other Marketing Materials produced by the Provider site to Members that EOHHS can reasonably determine influence the Member to enroll in the Contractor's MassHealth Plan or to disenroll from the Contractor's MassHealth Plan into another MassHealth Plan. This shall include direct mail campaigns sent by the Provider site to its patients who are Members. With one exception, described in **Section 2.11.B.3**, Provider Site Marketing is prohibited.

Qualified Health Plan (QHP) – plans certified as Qualified Health Plans (QHPs) by the Commonwealth Health Insurance Connector Authority (Health Connector), Massachusetts' Exchange in accordance with the Patient Protection and Affordable Care Act.

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

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

Region – A geographic area, specified by EOHHS and as listed in **Appendix F,** in which a Contractor has contracted with EOHHS to serve MassHealth members.

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

Risk Adjusted Capitation Rate – the Base Capitation Rate as adjusted to reflect acuity of the Enrollees in accordance with **Section 4** of the Contract.

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

Secretary – the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

Serious Emotional Disturbance (SED) – a behavioral health condition that meets the definition set forth in the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations or the definition set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States.

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 designated as such by the Department of Public Health (DPH) and identified by EOHHS.

Service Area - a geographic area, specified by EOHHS and as listed in **Appendix R** of the Contract

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

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

Social Determinants of Health – Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

State Fiscal Year – the twelve month period commencing July 1 and ending June 30 and designated by the calendar year in which the fiscal year ends (e.g., State Fiscal Year 2017 ends June 30, 2017).

Substance Use Disorder (SUD) Risk Sharing Services – For purposes of **Section 4.5.I** and **Appendix D**, the following services as set forth in **Appendix C**: Residential Rehabilitation Services, Recovery Support Navigator, and Recovery Coaching.

TPL Indicator Form – forms supplied to inpatient hospitals by EOHHS used to notify the Contractor when the hospital discovers that an Enrollee is enrolled in another health plan and used by the Contractor to notify EOHHS that an Enrollee is covered under the Contractor's commercial plan or a Qualified Health Plan offered through the Exchange..

Transitional Care Management – the evaluation of an Enrollee's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services, as described in **Section 2.5.C.2.**

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

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

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

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

SECTION 2. CONTRACTOR RESPONSIBILITIES

Section 2.1 Compliance

A. Regional Contract

1. The Contractor shall comply with all Contract requirements for all Services Areas in each Region for which it has contracted with EOHHS to serve MassHealth Members.

2. EOHHS may, at any time and in its sole discretion, request from the Contractor any information and reports related to the Contractor's ability to meet Access and Availability requirements set forth in **Section 2.9** for all Services Areas in each Region for which the Contractor has contracted with EOHHS to serve MassHealth Members. Based on such information, or other information available to EOHHS, EOHHS may, in its discretion, identify Service Areas for which it has determined that circumstances make it infeasible for the Contractor to maintain a network consistent with such Access and Availability requirements. If EOHHS identifies any such Service Area:

   a. EOHHS shall identify such Service Areas to the Contractor. The Contractor shall decide whether or not it wishes to cover such Service Areas.

      1) If the Contractor wishes to cover such a Service Area identified by EOHHS, the Contractor shall demonstrate to EOHHS' satisfaction that it is able to meet Access and Availability requirements set forth in **Section 2.9** for such Service Area. If it is able to demonstrate compliance to EOHHS' satisfaction, the Contractor may cover such Service Area and the Contractor shall be responsible for meeting all Contract requirements in such Service Area.

      2) If the Contractor does not wish to cover such a Service Area identified by EOHHS, EOHHS will not enroll Members with the Contractor for such Service Areas and the Contractor shall not be responsible for meeting Contract requirements in such Service Area.

   b. At any time, EOHHS may determine that circumstances have changed such that allowing the Contractor to opt out of covering a Service Area pursuant to this **Section 2.1.A.2** is no longer appropriate or necessary. In such cases, EOHHS will provide the Contractor with reasonable notice to come into compliance with Contract requirements for such Service Area by a specified date and resume enrolling Members with the Contractor in such Service Area in accordance with the readiness requirements set forth in **Section 2.2.B.1.f-g.** (For the purposes of such Section, the Operational Start Date shall be the date specified pursuant to this Section.)

B. General

Contractor shall comply, to the satisfaction of EOHHS, with (1) all provisions set forth in this Contract and (2) all applicable provisions of state and federal laws, regulations, and waivers.

C. Federal Managed Care Law

The Contractor shall comply with 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.

D. Conflict of Interest

Neither the Contractor nor any Material Subcontractor shall, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual or other business interest in any entity performing MCO enrollment functions for EOHHS, the CSC Enrollment Vendor and subcontractor(s) if any).

E. Systems Interface

The Contractor or its designated sub-contractor shall take all steps necessary, as determined by EOHHS, to ensure that the Contractor's systems are always able to interface with the Medicaid Management Information System (MMIS), the Virtual Gateway, and other EOHHS IT applications.

F. Special Kids Special Care (SKSC) Program

Appendix W, in addition to other applicable provisions of this Contract, shall set forth the parties' obligations with respect to Enrollees in the SKSC Program. The Contractor shall serve Enrollees in the SKSC Program in accordance with **Appendix W**.

Section 2.2 Contract Transition/Contract Readiness

A. Contract Transition Phase

The Contractor shall comply with all requirements related to the Transition Phase of the Contract as detailed herein. The Contract Transition Phase includes, but is not limited to, the period between the Contract Effective Date and the Contract Operational Start Date.

1. Transition Schedule

The Transition Phase will begin after the Contract is executed. The Transition Phase must be completed no later than the Contract Operational Start Date.

2. Transition Workplan

a. No later than five business days following the Contract Effective Date, the Contractor shall submit to EOHHS, for its review and approval, a Transition Workplan which shall

be used by EOHHS to monitor the Contractor's progress toward achieving Contract Readiness, as detailed in **Section 2.2.B** below. The Transition Workplan must address all of the items listed in **Section 2.2.B.1.b**., at a minimum, for each Region in which the Contractor has contracted with EOHHS to serve Members.

b. The Transition Workplan must list each task, the date by which it will be completed, how it will be completed, and the documentation that will be provided to EOHHS as evidence that the task has been completed.

B. Contract Readiness Review Requirements

During the Transition Phase, EOHHS will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

1. Readiness Review Overview

a. EOHHS will conduct a Readiness Review of the Contactor that may include, at a minimum, one on-site review. This Readiness Review shall be conducted prior to enrollment of Members with the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS. EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become managed care eligible.

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

1) Network Provider composition and access, in accordance with **Section 2.7**;

2) Staffing, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with **Section 2.3.A**;

3) Marketing materials, in accordance with **Section 2.11**;

4) Capabilities of Material Subcontractors, in accordance with **Section 2.3.C.2**;

5) Care Management capabilities, in accordance with **Section 2.5.E**;

6) Content of Provider Contracts, including any Provider Performance Incentives, in accordance with **Sections 2.7.B, 2.13.D** and **5.1.H**;

7) Contractual Agreements with Community Partners, in accordance with **Sections 2.5.F** and **2.5.G**;

8) Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with **Section 2.10**;

9) Comprehensiveness of quality management/quality improvement strategies, in accordance with **Section 2.13**;

10) Comprehensiveness of Utilization Management strategies, in accordance with **Section 2.6.D**;

11) Internal Grievance and Appeal policies and procedures, in accordance with **Section 2.12**;

12) Fraud and Abuse and program integrity, in accordance with **Section 2.3.C.3**;

13) Financial solvency, in accordance with **Section 2.15**;

14) 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 2.14**, including IT testing and security assurances; and

15) Approved ACO Agreements with MCO-Administered ACOs, in accordance with **Section 2.21** and **Appendix P**.

c. The scope of the Readiness Review will also include an assessment of the Contractor's ability and capability to perform satisfactorily in the areas set forth in 42 CFR 438.66(d)(4).

d. MassHealth Members shall not be enrolled into the Contractor's 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, except as provided below.

e. EOHHS will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion, allow the Contractor to propose a plan to remedy all deficiencies prior to the Contract Operational Start Date.

f. EOHHS may, in its discretion, postpone the Contract Operational Start Date for any Contractor that 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 EOHHS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

g. Alternatively, EOHHS may, in its discretion, enroll MassHealth Members into the Contractor's Plan as of the Contract Operational Start Date provided the Contractor

and EOHHS agree on a corrective action plan to remedy any deficiencies EOHHS identifies pursuant to this Section.

2. Contract Readiness Review Responsibilities

The Contractor shall:

a. Demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet all Contract requirements identified in the Readiness Review no later than 15 business days prior to the Contract Operational Start Date. The Contractor shall provide EOHHS with a certification, in a form and format specified by EOHHS, demonstrating such readiness;

b. At the request of EOHHS, provide to EOHHS or its designee, access to all facilities, sites, and locations at which one or more services or functions required under this Contract occurs or is provided;

c. At the request of EOHHS, provide to EOHHS or its designee, access to all information, materials, or documentation pertaining to the provision of any service or function required under this Contract within five business days of receiving the request; and

d. Provide EOHHS with a Remedy Plan within five business days after being informed of any deficiency EOHHS identifies during the Readiness Review. EOHHS, may, in its discretion, modify or reject any such Remedy Plan, in whole or in part.

3. The readiness provisions in this **Section 2.2.B** shall also apply, as determined appropriate by EOHHS, upon the implementation of changes in scope to this Contract and new programs or initiatives as described in **Sections 5.7.A and 5.7.E** of this Contract, including but not limited to the introduction of LTSS and as further specified by EOHHS;

C. Continuity of Care for New Enrollees

The Contractor shall develop and implement policies and procedures to ensure continuity of care for new Enrollees that are enrolling with the Contractor from another MassHealth-contracted MCO, an Accountable Care Partnership Plan, a Primary Care ACO, another MassHealth-contracted ACO, the PCC Plan, or a commercial carrier. Such policies and procedures:

1. Shall be for the purpose of minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary MCO Covered Services;

2. Shall address continuity of care for all such Enrollees and include specific policies and procedures for the following individuals at a minimum:

a. Enrollees who, at the time of their Enrollment:

1) Are pregnant;

2) Have significant health care needs or complex medical conditions;

3) Have autism spectrum disorder (ASD) and are currently receiving ABA Services, either through MassHealth, another Accountable Care Partnership Plan, a MassHealth-contracted MCO, or a commercial carrier and have a current prior authorization for ABA Services in place;

4) Are receiving ongoing services such as dialysis, home health, chemotherapy and /or radiation therapy;

5) Are hospitalized; or

6) Are receiving treatment for behavioral health or substance use; and

b. Enrollees who have received prior authorization for MCO Covered Services including but not limited to:

1) Scheduled surgeries;

2) Out-of-area specialty services;

3) Durable medical equipment (DME) or prosthetics, orthotics, and supplies (POS);

4) Physical therapy (PT), occupational therapy (OT), or speech therapy (ST); or

5) Nursing home admission;

3. Shall include, at a minimum, provisions for:

a. Identifying and communicating with Enrollees who would benefit from continuity of care in accordance with this Section, and those Enrollees' providers (including but not limited to Network Providers);

b. Facilitating continuity of care so that new Enrollees may continue to see their current providers (including but not limited to Network Providers) for Medically Necessary MCO Covered Services for at least 30 days after the Effective Date of Enrollment, including but not limited to:

1) Ensuring that Enrollees currently receiving inpatient care (medical or Behavioral Health) from a hospital, including non-Network hospitals, at the time of their Enrollment may continue to receive such care from such hospital as long as such care is Medically Necessary. The Contractor shall make best efforts to contact such hospital to ensure such continuity of care;

2) Ensuring that, for at least 30 days after the Effective Date of Enrollment, new Enrollees receiving outpatient medical, Behavioral Health, or substance use

disorder care, including but not limited to Enrollees with upcoming appointments, ongoing treatments or services, or prior authorizations, may continue to seek and receive such care from providers (including non-Network) with whom they have an existing relationship for such care;

3) Ensuring that, for at least 30 days after the Effective Date of Enrollment, new Enrollees with any of the following may have continued access. The Contractor shall ensure such continuity by providing new authorization or extending existing authorization, if necessary, without regard to Medical Necessity criteria, for at least the required 30 day period:

   a) Durable medical equipment (DME) that was previously authorized by MassHealth, a MassHealth-contracted MCO, Accountable Care Partnership Plan, or a commercial carrier;

   b) Prosthetics, orthotics, and supplies (POS) that was previously authorized by MassHealth, a MassHealth-contracted MCO, Accountable Care Partnership Plan, or a commercial carrier; and

   c) Physical therapy (PT), occupational therapy (OT), or speech therapy (ST) that was previously authorized by MassHealth, a MassHealth-contracted MCO, Accountable Care Partnership Plan, or a commercial carrier.

4) Otherwise making accommodations for:

   a) Upcoming appointments;

   b) Ongoing treatments or services;

   c) Pre-existing prescriptions;

   d) Scheduled and unscheduled inpatient care (medical and Behavioral Health); and

   e) Other medically necessary services.

c. Ensuring that all such providers are able to confirm or obtain any authorization, if needed, for any such services from the Contractor;

d. Honoring all prior authorizations and prior approvals for services for the duration of such prior authorizations and prior approvals or, if the Contractor chooses to modify or terminate a prior authorization and prior approval, then the Contractor must 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;

e. Ensuring appropriate medical record documentation or any continuity of care or transition plan activities as described in this Section;

f. Ensuring that all Enrollees, including new Enrollees, may access Emergency Services at any emergency room, including from out-of-Network Providers, and that such Services are provided at no cost to the Enrollee, as described in **Section 2.9**;

g. For Enrollees who have an existing prescription, providing any prescribed refills of such prescription, unless Contractor has a prior authorization policy as described in **Section 2.6.B.1.c.2** and such policy requires a prior authorization for such prescription. If Contractor requires such prior authorization, Contractor shall, at a minimum, provide a 72 hour supply of such medication as described in **Section 2.6.B.1.c .2**;

h. For pregnant Enrollees, the following:

1) If a pregnant Enrollee enrolls with the Contractor during a transition period after the Contract Effective Date, to be specified by EOHHS, such Enrollee may choose to remain with her current provider of obstetrical and gynecological services, even if such provider is not in the Contractor's Provider Network;

2) The Contractor is required to 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

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;

i. For Enrollees affiliated with other state agencies, coordination and consultation with such agencies as described in **Sections 2.5.C and 2.6.F**;

j. For any Enrollee who is identified by EOHHS or by the Contractor as an Enrollee with Special Health Care Needs, completing a Transition Plan no later than 10 business days from the date the Contractor becomes aware of the Enrollee's health status or condition, but in no case later than 45 days from the Effective Date of Enrollment. Such Transition Plan shall be specific to each such Enrollee's needs, and shall include processes that address, at a minimum:

1) Medical record documentation;

2) Completion of a Care Needs Screening;

3) Evaluation for Care Management;

4) Coordination and consultation with the Enrollee's existing Providers;

5) Review of all existing prior authorizations and prescriptions; and

6) Historical utilization data.

k. Accepting and utilizing medical records, claims histories, and prior authorizations from an Enrollee's previous MassHealth-contracted MCO or Accountable Care Partnership Plan. Provisions shall also include accepting and utilizing available medical records, claims histories, and prior authorizations from an Enrollee's previous commercial carrier, to the extent such information is made available by the Enrollee, the Enrollee's provider, or MassHealth. The process shall require the Contractor to, at a minimum:

1) Ensure that there is no interruption of MCO Covered Services for Enrollees;

2) Accept the transfer of all medical records and care management data, as directed by EOHHS;

3) Accept the transfer of all administrative documentation, as directed by EOHHS, including but not limited to:

a) Provider Fraud investigations;

b) Complaints from Enrollees;

c) Grievances from Providers and Enrollees;

d) Quality Management Plan; and

e) Quality Improvement project records;

l. Maintaining adequate staffing to fulfill all Contractual obligations throughout the duration of the Contract;

m. As directed by EOHHS, participating in any other activities determined necessary by EOHHS to ensure the continuity of care for Enrollees, including making best efforts to:

1) Outreach to New Enrollees within two business days of such New Enrollee's Effective Date of Enrollment for a period at the start of the Contract to be specified by EOHHS and expected to last no more than 120 days from the Contract Operational Start Date. Such outreach may include telephone calls, mail, or email, as appropriate and compliant with all applicable laws;

2) Obtain any necessary consents from Members who were formerly Enrollees or Enrollees leaving the Contractor's Plan, in order to transfer certain information specified by EOHHS to such Member's or Enrollee's new MCO or ACO; and

3) As directed by EOHHS, transferring all information related to prior authorizations;

n. For Enrollees actively receiving ABA Services for autism spectrum disorder, developing protocols to ensure continuity of these services for a minimum of 90 days after such Enrollee is enrolled with the Contractor. Such protocol shall include the use of single-case agreements, full acceptance and implementation of existing prior authorizations for ABA Services, and individual transition plans.

4. Shall include designating a specific contact person to respond to EOHHS requests and concerns related to continuity of care. The Contractor shall provide EOHHS with such individual's name, telephone number, and email address, and shall ensure such individual is available to EOHHS during business hours and at other times specified by EOHHS; and

5. Shall be submitted to EOHHS for approval on a date specified by EOHHS.

Section 2.3 Administration and Contract Management

A. Organization, Staffing and Key Personnel

1. Structure and Governance

The Contractor shall:

a. Meet the definition of an MCO, as set forth in **Section 1**;

b. Be located within the United States;

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

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

e. Establish and maintain interdepartmental structures and processes to support the operation and management of its MassHealth 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 integral to the Plan, Enrollee-focused, and oriented to recovery and rehabilitation from behavioral health conditions.

f. 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. The organizational chart must 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. For all organizational charts, the Contractor shall indicate any staff vacancies and provide a timeline for when such vacancies are anticipated to be filled;

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

2. Key Personnel and Other Staff

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

a. The following roles shall be Key Personnel:

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

2) The Contractor's Chief Medical Officer/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 related to addressing the care needs of children, Utilization Management programs, and the review of all appeals decisions that involve the denial of or modification of a requested Covered Service;

3) The Contractor's Pharmacy Director who shall attend Pharmacy Director meetings as described in this Contract and further directed by EOHHS;

4) The Contractor's Behavioral Health Director, who shall be responsible for Contractor's activities related to BH Services and related Care Delivery and Care Management activities, and for all BH-related interaction with EOHHS, including coordination of BH Services and DMH Community-Based Services;

5) The Contractor's Chief Financial Officer, who shall be authorized to sign and certify Contractor's financial documents, as described in this Contract and further specified by EOHHS;

6) 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;

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

a) 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 and ensuring that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Enrollees with physical or mental disabilities;

b) 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; and

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

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

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

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

11) The Contractor's Quality Key Contact, who shall oversee the Contractor's quality management and quality improvement activities, including those described in Section 2.13 and other quality activities as further specified by EOHHS; and

12) Any other positions designated by EOHHS, including but not limited to any additional positions related to future policy changes such as the inclusion of LTSS as described in **Section 6.6.D.1**.

b. The Contractor shall appoint Key Personnel as follows:

1) The Contractor shall appoint an individual to each of the roles listed in **Section 2.3.A.2**. The Contractor may appoint a single individual to more than one such role;

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

3) All individuals assigned to Key Personnel roles shall, for the duration of the Contract, be employed by the Contractor and assigned primarily to perform their job functions related to this Contract;

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

5) 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. If such actions fail to ensure such compliance to EOHHS' satisfaction, EOHHS may invoke the corrective action provisions described in **Section 5.3.L**;

c. Administrative Staff

The Contractor shall employ sufficient Massachusetts-based, dedicated administrative staff and have sufficient organizational structures in place to comply with all of the requirements set forth herein, including, but not limited to, specifically designated administrative staff dedicated to the Contractor's activities related to:

1) The Contractor's relationships with CPs and management of the ACO/MCO-CP Agreements;

2) Risk stratification;

3) Care Management; and

4) Population health initiatives and programs

B. Contract Management and Responsiveness to EOHHS

In addition to the other requirements of this Contract, Contractor shall ensure and demonstrate appropriate responsiveness to EOHHS requests related to this Contract, as follows:

1. Performance reviews

a. Contractor shall attend regular performance review meetings held by EOHHS at EOHHS' offices, or at another location determined by EOHHS, each quarter or more frequently in EOHHS' discretion;

b. Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present in person at such meetings, as requested by EOHHS, including but not limited to Contractor's MassHealth Executive Director;

c. Contractor shall prepare materials and information for such meetings as further directed by EOHHS, including but not limited to materials and information such as:

1) Reports, in a form and format approved by EOHHS, on Contractor's performance under this Contract, including but not limited to measures such as:

a) Costs of care for Enrollees by Rating Category and category of service;

b) Performance reporting information;

c) Quality Measure performance;

d) Measures of Enrollee utilization across categories of service and other indicators of changes in patterns of care;

e) Variation and trends in any such performance measures at the level of individual PCPs;

f) Completeness and validity of any data submissions made to EOHHS;

g) Opportunities the Contractor identifies to improve performance, and plans to improve such performance, including plans proposed to be implemented by the Contractor for PCPs or other Network Providers;

h) Changes in Contractor's staffing and organizational development;

i) Performance of Material Subcontractors including but not limited to any changes in or additions to Material Subcontractor relationships; and

j) Utilization metrics;

k) Any other measures deemed relevant by Contractor or requested by EOHHS;

2) Updates and analytic findings from any reviews requested by EOHHS, such as reviews of data irregularities;

3) Updates on any action items and requested follow-ups from prior meetings or communications with EOHHS; and

d. Contractor shall, within two business days following each performance review meeting, prepare and submit to EOHHS for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by EOHHS;

2. Timely response to EOHHS requests

a. Contractor shall respond to any EOHHS requests for review, analysis, information, or other materials related to Contractor's performance of this Contract by the deadlines specified by EOHHS, including but not limited to, for most requests such as those described in this Section, providing a sufficient response within one week of receiving the request. Such requests may include but are not limited to requests for:

1) Records from Contractor's Health Information System, claims processing system, Encounter Data submission process, or other sources, to assist Contractor and EOHHS in identifying and resolving issues and inconsistencies in Contractor's data submissions to EOHHS;

2) Analysis of utilization, patterns of care, cost, and other characteristics to identify opportunities to improve Contractor's performance on any cost or quality measures related to this Contract;

3) Financial and data analytics, such as the Contractor's payment rates to Network Providers as a percent of MassHealth's fee schedules;

4) Documentation and information related to Contractor's care delivery, Care Management, or Community Partners responsibilities, to assist EOHHS with understanding Contractor's activities pursuant to these requirements;

5) Information about Contractor's member protections activities, such as Grievances and Appeals;

6) Documentation and information related to Contractor's Program Integrity activities as described in **Section 2.3.C.3**;

7) Documentation, analysis, and detail on the metrics evaluated in the Contractor's Quality Improvement performance and programming; and

8) 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

b. If the Contractor fails to satisfactorily respond within the time requested by EOHHS without prior approval from EOHHS for a late response, EOHHS may take corrective action or impose sanctions in accordance with this Contract.

3. Performance Reporting

EOHHS may, at its discretion and at any time, identify certain Contract requirements and other performance and quality measures about which the Contractor must 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:

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

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

4. Ad hoc meetings

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

b. Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present in person at such meetings, as requested by EOHHS, including but not limited to Contractor's MassHealth Executive Director;

c. Contractor shall prepare materials and information for such meetings as further directed by EOHHS;

5. Participation in EOHHS Efforts

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

a. Efforts to promote the delivery of services in a Culturally and Linguistically 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;

b. EOHHS activities related to Program Integrity;

c. 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;

d. Activities related to EOHHS' implementation and administration of its Delivery System Reform efforts, including but not limited to efforts related to validation of provider identification mapping;

e. Activities as directed by EOHHS to facilitate EOHHS' implementation of its ACO Program, including but not limited to participating in performance review meetings, learning collaboratives, and joint performance management activities;

f. MCO learning collaboratives and other meetings or initiatives by EOHHS to facilitate information sharing and identify best practices among MCOs. The Contractor shall share information with EOHHS and others as directed by EOHHS regarding the Contractor's performance under this Contract, including but not limited to information on the Contractor's business practices, procedures, infrastructure, and information technology;

g. EOHHS efforts related to the development of policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, that support access, coordination, and continuity of behavioral health care, including substance use treatment related to the opioid epidemic and which facilitate access to appropriate BH services and timely discharge from the emergency department. Such policies or programs may include, but are not limited to, the development of:

    1) Specialized inpatient services;

    2) New diversionary and urgent levels of care;

    3) Expanded substance use disorder treatment services; and

    4) Services and supports tailored to populations with significant behavioral health needs, including justice involved and homeless populations;

h. Enrollment, disenrollment, or attribution activities related to this Contract;

i. Training programs;

j. Coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor;

k. Workgroups and councils, including but not limited to workgroups related to reporting or data submission specifications;

l. Educational sessions for EOHHS staff, such as but not limited to trainings for EOHHS' Customer Service Team;

m. Site visits and other reviews and assessments by EOHHS;

n. Any other activities related to this Contract; and

o. As directed by EOHHS, the Contractor shall comply with all applicable requirements resulting from EOHHS initiatives, including but not limited to, the development and implementation of Accountable Care Organizations, BH and LTSS Community Partners, and alternative payment methodologies activities. Such applicable requirements may include, but shall not be limited to, those relating to the provision of Care Management and coordination of services for Enrollees.

6. Policies and Procedures for Core Functions

The Contractor shall develop, maintain, and provide to EOHHS upon request, policies and procedures for all core functions necessary to effectively and efficiently manage the MassHealth population and meet the requirements outlined in this Contract. All policies and procedures requiring EOHHS approval shall be documented and shall include the dates of approval by EOHHS. These policies and procedures shall include, but are not limited to, the following topics:

a. Response to violations of Enrollees' privacy rights by staff, Providers or subcontractors;

b. Non-discrimination of MassHealth Enrollees;

c. Non-restriction of Providers advising or advocating on an Enrollee's behalf;

d. Appeal rights for certain minors who under the law may consent to medical procedures without parental consent;

e. Enrollee cooperation with those providing health care services;

f. Marketing activities that apply to the Plan, Providers and subcontractors as well as the Contractor's procedures for monitoring these activities;

g. Cost-sharing by Enrollees;

h. Advance directives;

i. Assisting Enrollees in understanding their benefits and how to access them;

j. Access and availability standards;

k. Enrollees' right to be free from restraint or seclusion used as a means of coercion or retaliation;

l. The provision of Culturally and Linguistically Appropriate Services;

m. Practice guidelines in quality measurement and improvement activities;

n. Compliance with Emergency Services and Poststabilization Care Services requirements as identified in 42 CFR 438.114;

o. Procedures for tracking appeals when Enrollees become aware of the Adverse Action, in the event that no notice had been sent;

p. Handling of complaints/Grievances sent directly to EOHHS;

q. Process used to monitor Provider and subcontractor implementation of amendments and improvements;

r. Retention of medical records;

s. Engagement and coordination with BH CPs and LTSS CPs, as described in **Sections 2.5.F** and **2.5.G**;

t. Compliance with all CBHI requirements as set forth in this Contract;

u. Care Management;

v. Risk stratification; and

w. Claims processing.

C. Other Contract Management Requirements

1. Customer Service Center (CSC) Enrollment Vendor Education

The Contractor shall participate in educational sessions, at the request of EOHHS, to update EOHHS staff and its designated CSC Enrollment Vendor regarding information which would assist prospective Enrollees in evaluating the Contractor's Plan. These educational activities may include multiple presentations per Contract Year at EOHHS, Plan sites and CSC Enrollment Vendor offices.

2. Material Subcontracts/Subcontractors

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

b. All Material Subcontracts must 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 using the template provided by EOHHS and attached hereto as **Appendix I**, as may be modified by EOHHS from time-to-time, at least 60 days prior to the date the Contractor expects to execute the Material Subcontract. Among other things required in the checklist, the Contractor must

describe the process for selecting the Material Subcontractor, including the selection criteria used.

c. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the checklist.

d. The Material Subcontract shall:

1) Be a written agreement;

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;

3) Provide for imposing sanctions, including contract termination, if the Material Subcontractor's performance is inadequate;

4) Require the Material Subcontractor to comply with all applicable Medicaid laws, regulations, and applicable subregulatory guidance;

5) Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the Material Subcontract requires the Material Subcontractor to agree as follows. See also **Section 5.4**.

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

b) The Material Subcontractor will make its premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above;

e. The Contractor shall monitor any Material Subcontractor's performance on an ongoing basis and perform a formal review annually. If any deficiencies or areas for improvement are identified, the Contractor shall require the Material Subcontractor to take corrective action. Upon request, the Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result.

f. Upon notifying any Material Subcontractor, or being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall

notify EOHHS in writing no later than the same day as such notification, and shall otherwise support any necessary member transition or related activities as described in **Section 2.2** and elsewhere in this Contract.

g. In accordance with **Appendix A**, the Contractor shall submit to EOHHS an annual list of all Material Subcontractors. Such annual report shall include notification if 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 above-mentioned list and report.

h. The Contractor shall make best efforts to ensure that all Material Subcontracts 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.

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

j. Notwithstanding any relationship the Contractor may have with a subcontractor, including Material subcontractors, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract; and

k. The Contractor shall remain fully responsible for meeting all of the terms and requirements (including all applicable state and federal regulations) of the Contract 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.

l. The Contractor shall inform all Material Subcontractors of Enrollee grievance and appeal rights as described in **Section 2.8.A.7** and **Section 2.12**.

3. Program Integrity Requirements

a. Program Integrity Requirements

The Contractor shall:

1) General Provisions

a) Comply with all applicable federal and state program integrity laws and regulations regarding fraud, waste and abuse, including but not limited to, the Social Security Act and 42 CFR Parts 438, 455, and 456.

b) Have adequate Massachusetts-based staffing and resources to assist the Contractor in preventing and detecting potential fraud, waste and abuse. Staff conducting program integrity activities for the Contractor shall be familiar with MassHealth and state and federal regulations on fraud, waste and abuse.

c) Have written internal controls and policies and procedures in place that are designed to prevent, detect, reduce, investigate, correct and report known or suspected fraud, waste and abuse activities.

d) In accordance with 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 Section 6032, the Contractor's policies, and the rights of employees to be protected as whistleblowers.

e) Meet with EOHHS at least quarterly to discuss fraud, waste and abuse, audits, and overpayment issues.

f) 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;

2) Compliance Plan and Anti-Fraud, Waste, and Abuse Plan

Have in place a Compliance Plan and Anti-Fraud, Waste, and Abuse Program Plan in accordance with this Section, copies of which shall be provided to EOHHS, in a form and format specified by EOHHS, in accordance with **Appendix A,** by the Contract Operational Start Date and annually thereafter. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

a) Compliance Plan. In accordance with 42 CFR 438.608, the Contractor shall have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against Fraud, Waste and Abuse. At a minimum, the compliance plan must include the following:

(i) 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;

(ii) The designation of a compliance officer and a compliance committee, as described in 42 CFR 438.608, that is accountable to senior management;

(iii) 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.

(iv) Effective training and education for the Contractor's employees, including but not limited to the Contractor's compliance officer and senior management;

(v) Effective lines of communication between the compliance officer and the Contractor's employees, as well as between the compliance officer and EOHHS;

(vi) Enforcement of standards through well-publicized disciplinary guidelines;

(vii) Provision for internal monitoring and auditing as described in 42 CFR 438.608;

(viii) 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

(ix) Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this Section;

b) Anti-Fraud, Waste, and Abuse Plan. The Contractor's Anti-Fraud, Waste, and Abuse Plan shall, at a minimum:

(i) Require that the reporting of suspected and confirmed fraud, waste, and abuse be done as required by this Contract;

(ii) 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. 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). With such submission, the Contractor shall provide details of such action; outline activities for employee education of federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, abuse, and waste, 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, Abuse, and Waste Plan;

(iii) 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;

(iv) Contain procedures designed to prevent and detect fraud, waste, and abuse in the administration and delivery of services under this Contract; and

(v) Include a description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

(a) A list of automated pre-payment claims edits;

(b) A list of automated post-payment claims edits;

(c) A description of desk audits performed on post-processing review of claims;

(d) A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

(e) A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

(f) A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials;

3) Report no later than five business days to EOHHS, in accordance with all other Contract requirements, all overpayments identified and recovered, specifying those overpayments due to potential fraud;

4) Report promptly to EOHHS, in accordance with 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;

5) Report no later than five business days to EOHHS, in accordance with 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;

6) Verify, in accordance with other Contract requirements, through sampling, whether services that were represented to be delivered by Providers were received by Enrollees;

7) Provide employees, subcontractors, and agents detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including whistleblower protections;

8) Report within five business days to EOHHS, in accordance with all other Contract requirements, any potential Fraud, Abuse, or waste that the Contractor identifies or, in accordance with EOHHS policies, directly to the Medicaid Fraud Unit;

9) Suspend, in accordance with all other Contract requirements and EOHHS policies, payments to Providers for which EOHHS determines there is a credible allegation of fraud pursuant to 42 CFR 455.23;

10) In accordance with Mass. Gen. Laws. ch. 12, section 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution;

11) Upon a complaint of Fraud, Waste or Abuse from any source or upon identifying any questionable practices, report the matter in writing to EOHHS within five business days;

12) First notify EOHHS and receive its approval prior to initiating contact with a Provider suspected of Fraud about the suspected activity;

13) Make diligent efforts to recover improper payments or funds misspent due to fraudulent, wasteful or abusive actions by the Contractor, or its parent organization, its Providers or its subcontractors;

14) Require Providers to implement timely corrective actions approved by EOHHS or terminate Provider Contracts, as appropriate;

15) Submit on an quarterly basis a fraud and abuse report according to the format specified by EOHHS, and submit ad hoc reports as needed, or as requested by EOHHS in accordance with **Appendix A**;

16) Have the CEO or CFO certify in writing on an annual basis to EOHHS, using the appropriate **Appendix A** certification checklist, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with this Contract and has not been made aware of any instances of Fraud and Abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS;

17) Notify EOHHS within two business days after contact by the Medicaid Fraud Division (MFD), the Bureau of Special Investigations (BSI) 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 subcontractors or Material Subcontractors, shall cooperate fully with the MFD, BSI and other agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud 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;

18) Notify EOHHS within one business day of any voluntary Provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity; and

19) With respect to overpayments:

    a) 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 60 calendar days of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment.

    b) If the Contractor identifies an overpayment prior to EOHHS:

        (i) The Contractor shall recover the overpayment and may retain any overpayments collected.

        (ii) The Contractor shall report the date of identification and collection, if any, quarterly on the Fraud and Abuse report.

c) If EOHHS identifies an overpayment prior to the Contractor, EOHHS may explore options up to and including recovering the overpayment from the Contractor.

b. Employee Education about False Claims Laws

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) If the Contractor is subject to such federal requirements, the Contractor must:

a) On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, via the appropriate **Appendix A** certification checklist or in another form acceptable to EOHHS, and signed under the pains and penalties of perjury, of compliance with such federal requirements;

b) 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

c) Initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.

3) Failure to comply with this Section may result in intermediate sanctions in accordance with **Section 5.3.K** of the Contract.

c. Fraud and Abuse Prevention Coordinator

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

1) Assessing and strengthening internal controls to insure claims are submitted and payments properly made;

2) Developing and implementing an automated reporting protocol within the claims processing system to identify billing patterns that may suggest Provider and/or Enrollee Fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

3) Conducting regular reviews and audits of operations to guard against Fraud and Abuse;

4) Receiving 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;

5) Educating 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

6) Establishing 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.

d. Obligation to Screen Employees and Contractors

In addition to the requirements set forth in **Section 2.8.H**, the Contractor shall use, and shall require its Providers to use, the OIG List of Excluded Individuals Entities (LEIE), and the list of other databases at **Appendix N**, upon initial hiring or contracting and on an ongoing monthly basis, or other frequency specified at **Appendix N**, to screen employees and contractors, including providers and subcontractors, to determine if any such individuals or entities are excluded from participation in federal health care programs. The Contractor shall notify EOHHS of any discovered exclusion of an employee, contractor, or Provider within two business days of discovery.

4. Continuity of Operations Plan

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

Section 2.4 Enrollment and Education Activities

A. Eligibility Verification

The Contractor shall:

1. Upon receipt of an enrollment, verify that the Enrollee is not already enrolled under the Contractor's commercial plan or a qualified health plan offered through the Exchange. If the Enrollee is covered under the Contractor's commercial plan or a Qualified Health Plan offered through the Exchange, the Contractor shall promptly submit to EOHHS a completed TPL Indicator Form in accordance with EOHHS's specifications; and

2. 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.

B. Enrollment

1. Enrollment in the Contractor's Plan shall occur at the sole discretion of the Member or EOHHS except as provided in **Section 2.4.C** below. The Contractor shall provide EOHHS with sufficient enrollment packages and Marketing materials to use as training materials and reference guides for EOHHS's CSC Enrollment Vendor staff and to be distributed by EOHHS's CSC Enrollment Vendor to Members and Enrollees upon request.

2. The Contractor shall:

a. 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;

b. Accept for enrollment all Members, as described in **Section 3.3** of the Contract, referred by EOHHS in the order in which they are referred without restriction, except that the Contractor shall not accept for enrollment any individual who is currently enrolled with the Contractor through its commercial plan or a Qualified Health Plan offered through the Exchange and shall notify EOHHS of such third party liability in accordance with **Section 2.19**;

c. Accept for enrollment in the Contractor's Plan, all Members identified by EOHHS at any time without regard to income status, physical or mental condition (such as cognitive, intellectual, mobility, psychiatric, and sensory disabilities as further defined by EOHHS), age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, status as a Member, pre-existing conditions, expected health status, or need for health care services;

d. Be responsible to provide or arrange all MCO Covered Services required to be provided by the Contractor to Enrollees under this Contract to each Enrollee as of 12:01 a.m. on the Effective Date of Enrollment, as specified by EOHHS, until such time as provided in **Section 2.4.D**;

e. Provide New Enrollees, with an identification card for the Contractor's Plan. The Contractor shall:

1) Mail an identification card to all Enrollees no later than 15 business days after the Enrollee's Effective Date of Enrollment;

2) The Contractor shall ensure (pursuant to 42 USC 1396u-2(g)) that all identification cards issued by the Contractor to Enrollees include a code or some other means of allowing a hospital and other providers to identify the

Enrollee as a MassHealth Member. The Enrollee identification card must also include:

a) The name of the Contractor;

b) The Enrollee's name;

c) A unique identification number for the Enrollee other than the Enrollee's SSN;

d) The Enrollee's MassHealth identification number;

e) The name and relevant telephone number(s) of the Contractor's customer service number;

f) The name and customer service number, BIN, PCN, and group number of the Contractor's pharmacy benefit manager; and

g) The name and customer service number of the Contractor's behavioral health Material Subcontractor, if applicable.

f. Provide New Enrollees with Enrollee Information that meets the requirements of **Sections 2.10.C**. and D including a Provider directory that meets the requirements of **Section 2.7.E.** and an Enrollee handbook based on a model provided by EOHHS, as further directed by EOHHS, that contains the Enrollee Information specified below. Such Enrollee Information shall be provided either prior to or during the Enrollee orientation required under **Section 2.4.F**. The Contractor must submit such Enrollee Information to be reviewed and approved by EOHHS at least 60 days prior to publication. Such Enrollee Information must be written in a manner, format and language that is easily understood at a reading level of 6.0 and below. The Enrollee Information must be made available in Prevalent Languages and in Alternative Formats free-of-charge, including American Sign Language video clips. The Enrollee Information, shall include, but not be limited to, a description of the following:

1) How to access MCO Covered Services, including the amount, duration and scope of MCO Covered Services in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including authorization requirements, information regarding applicable access and availability standards and any cost sharing, if applicable;

2) How to access Non-MCO Covered Services, including any cost sharing, if applicable, and how transportation to such services may be requested. The Contractor shall also inform Enrollees of the availability of assistance through the MassHealth Customer Service Center for help with determining where to access such services;

3) How to access Behavioral Health Services and the procedures for obtaining such services, including through self-referral, the Contractor's toll-free telephone line(s), or referral by family members or guardians, a Provider, PCP or community agency;

4) Information related to the Contractor's MCO-administered ACOs, including but not limited to who the Contractor's MCO-Administered ACOs are, how they can be accessed by Enrollees, which PCPs are in these ACOs, and any differences in referrals or other policies if the Enrollee is attributed to an MCO-Administered ACO;

5) How to access Contractor's BH CPs and LTSS CPs, including through self-referral, and information about BH CPs and LTSS CPs;

6) The name and customer services telephone number for all Material Subcontractors that provide MCO Covered Services to Enrollees unless the Contractor retains all customer service functions for such MCO Covered Services;

7) The MCO Covered Services, including Behavioral Health Services, that do not require authorization or a referral from the Enrollee's PCP, for example, family planning services or individual behavioral health outpatient therapy;

8) The extent to which, and how, Enrollees may obtain benefits, including Emergency Services and family planning services, from out-of-network providers;

9) The role of the PCP, the process for selecting and changing the Enrollee's PCP, and the policies on referrals for specialty care and for other benefits not furnished by the Enrollee's PCP;

10) How to obtain information about Network Providers;

11) The extent to which, and how, after-hours and Emergency Services and Poststabilization Care Services are covered, including:

    a) What constitutes an Emergency Medical Condition, Emergency Services, and Poststabilization Care Services;

    b) The fact that prior authorization is not required for Emergency Services;

    c) How to access the Contractor's 24-hour Clinical Advice and Support Line,

d) The process and procedures for obtaining Emergency Services, including the use of the 911-telephone system;

e) The services provided by Emergency Services Programs (ESPs) and how to access them;

f) The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services; and

g) The fact that the Enrollee has a right to use any hospital or other setting for Emergency Services;

12) Enrollee cost sharing;

13) How to obtain care and coverage when outside of the Contractor's Region;

14) Any restrictions on freedom of choice among Network Providers;

15) The availability of free oral interpretation services at the Plan in all non-English languages spoken by Enrollees and how to obtain such oral interpretation services;

16) The availability of all written materials that are produced by the Contractor for Enrollees in Prevalent Languages and how to obtain translated materials;

17) The availability of all written materials that are produced by the Contractor for Enrollees in Alternative Formats free-of-charge and how to access written materials in those formats and the availability of free auxiliary aids and services, including at a minimum, services for Enrollees with disabilities;

18) The toll-free Enrollee services telephone number and hours of operation, and the telephone number for any other unit providing services directly to Enrollees;

19) The rights and responsibilities of Enrollees, including but not limited to, those Enrollee rights described in **Section 5.1.L**;

20) Information on the availability of and access to Ombudsman services, including contact information for the Ombudsman, in accordance with **Section 2.12.A.8**;

21) Information on Grievance, Internal Appeal, and Board of Hearing (BOH) procedures and timeframes, including:

a) The right to file Grievances and Internal Appeals;

b) The requirements and timeframes for filing a Grievance or Internal Appeal;

c) The availability of assistance in the filing process;

d) The toll-free numbers that the Enrollee can use to file a Grievance or an Internal Appeal by phone;

e) The fact that, when requested by the Enrollee, MCO Covered Services will continue to be provided if the Enrollee files an Internal Appeal or a request for a BOH hearing within the timeframes specified for filing, and that the Enrollee may be required by EOHHS to pay the cost of services furnished while a BOH Appeal is pending, if the final decision is adverse to the Enrollee;

f) The right to obtain a BOH hearing;

g) The method for obtaining a BOH hearing;

h) The rules that govern representation at the BOH hearing; and

i) The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information;

j) Information on advance directives in accordance with **Section 5.1.E**;

k) Information on the access standards specified in **Section 2.9.B**; and

l) Information on how to report suspected fraud or abuse;

22) Information about continuity and transition of care for new Enrollees;

23) Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventative Pediatric Healthcare Screening and Diagnosis (PPHS), as further directed by EOHHS; and

24) The information specified in **Section 6.1.J.2** related to any service the Contractor does not because of moral or religious grounds.

g. Accept verification of enrollment in the Contractor's Plan from EVS and require that Providers accept such verification of enrollment from EVS in lieu of the Contractor's ID card;

h. Provide a means to enable Providers to identify Enrollees in a manner that will not result in discrimination against Enrollees;

i. Provide Enrollees with written notice of any significant changes as follows:

1) Provide Enrollees with written notice of any significant changes in MCO Covered Services or Enrollee cost sharing, at least 30 days prior to the intended effective date of the change. Such notice shall be reviewed and approved by EOHHS prior to distribution to Enrollees. The Contractor shall make best efforts to provide EOHHS with draft materials for review 60 days prior to the effective date of such change;

2) Provide Enrollees with written notice of any significant change to the Provider directory at least 30 days before the intended effective date of the change or as soon as the Contractor becomes aware of such change, subject to Section 2.4.B.2.j below. The Contractor shall make best efforts to provide EOHHS with draft materials for review 60 days prior to the effective date of such change;

3) A significant change shall include, but not be limited to:

a) 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, within the Contractor's network, in which case the Contractor must provide notice of such termination or non-renewal to all Enrollees in the terminated Provider's coverage area and in all bordering coverage area;

b) A change to the Contractor's behavioral health subcontractor, if it subcontracts Behavioral Health Services;

c) A change to the Contractor's pharmacy benefits manager;

d) A termination or non-renewal of a contract with a private psychiatric hospital, 24-hour Behavioral Health Diversionary Services Provider, non-24 hour Behavioral Health Diversionary Services Provider, outpatient Behavioral Health Services Provider, Provider of services provided to children and adolescents through the Children's Behavioral Health Initiative, ESP Provider, community service agency, and a community health center. In such cases, the Contractor shall provide notice of such termination or non-renewal to all Enrollees in the terminated Provider's coverage area and in all bordering coverage area.

j. Provide Enrollees with written notice of termination of a Provider, the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice, to each Enrollee who received his or her Primary Care from, or was seen on a regular basis (which shall mean at least annually) by, the terminated Provider. Such written notice shall describe how the Enrollee's continuing need for services shall be met. Whenever possible, such notice shall be provided to Enrollees 30 days prior to such Provider termination. For Enrollees

receiving behavioral health services from a Provider that will be terminated, in addition to written notification, the Contractor shall ensure that care is transferred to another Provider in a timely manner to minimize any disruptions to treatment;

k. Make available, upon request, the following additional information in a format approved by EOHHS:

1) Information on the structure and operation of the Contractor; and

2) Information on physician incentive plans; and

l. As directed by EOHHS, the Contractor's Enrollee materials, including but not limited to the Enrollee Handbook, shall include a description of the CANS Tool and its use in Behavioral Health Clinical Assessments and in the Discharge Planning process from Inpatient Mental Health Services and Community Based Acute Treatment Services for Enrollees under the age of 21.

m. As further specified by EOHHS, the Contractor shall provide and maintain its Enrollee handbook, Provider directory, and its drug formulary on its website in a reasonably easy to find location

C. Notification of Birth and Coverage of Newborns

The Contractor shall:

1. Provide MCO Covered Services, and all other services required to be provided to Enrollees under this Contract, to all newborn Enrollees in accordance with this Contract, including but not limited to Section 2.6. During the first 30 days of the newborn Enrollee's enrollment with the Contractor:

a. For services for Primary Care, as defined in **Section 1**, the Contractor shall provide and cover such services when provided by out-of-network providers, without requiring any prior approval or permission to see such out-of-network provider.

b. For all services other than Primary Care, the Contractor shall comply with all requirements in this Contract.

c. The Contractor shall comply with all continuity of care requirements set forth in **Section 2.2.C** for newborn Enrollees**.**

2. Include language in its Provider Contracts that it is the Provider's contractual responsibility to submit the Notification of Birth (NOB) form for all births to Enrollees to EOHHS's MassHealth Enrollment Center within 10 calendar days of the newborn's date of birth, except in extenuating circumstances, and to follow all instructions accompanying the NOB form;

3. Inform pregnant Enrollees of the benefits of choosing a MassHealth health plan and Primary Care Provider for the Enrollee's newborn soon after the newborn's birth and advising the

Enrollee to contact MassHealth Customer Service or MassHealthChoices.com for additional information and options; and

4. Collaborate with EOHHS to establish a smooth and efficient process for reporting all newborns to be covered by the Contractor's Plan.

D. Disenrollment

1. The Contractor shall:

a. On each business day, obtain from EOHHS, via the HIPAA 834 Enrollment File, and process information pertaining to all Enrollee disenrollments, including the Effective Date of Disenrollment and disenrollment reason code;

b. No later than 30 days prior to the Enrollee's MassHealth redetermination date, and at the Contractor's discretion, contact the Enrollee and provide assistance (if required) to complete and return to MassHealth the redetermination form;

c. At a minimum, continue to provide MCO Covered Services, and all other services required under this Contract, to Enrollees through 11:59 p.m. on the Effective Date of Disenrollment, as specified by EOHHS;

d. Demonstrate a satisfactorily low voluntary Enrollee disenrollment rate, as determined by EOHHS, as compared with other MassHealth Accountable Care Partnership Plans and MassHealth-contracted MCOs for Enrollees in comparable Rating Categories;

2. The Contractor's Request for Enrollee Disenrollment

a. The Contractor shall not request the disenrollment of any Enrollee because of:

1) an adverse change in the Enrollee's health status;

2) the Enrollee's utilization of medical services, including but not limited to the Enrollee making treatment decisions with which a provider or the Contractor disagrees (such as declining treatment or diagnostic testing);

3) missed appointments by the Enrollee;

4) the Enrollee's diminished mental capacity, or

5) the Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when the Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either the particular Enrollee or other Enrollees).

b. As further specified by EOHHS and in accordance with 130 CMR 508.003(D), the Contractor may submit a written request to EOHHS to disenroll an Enrollee as follows:

1) The Contractor shall submit the written request in a form and format specified by EOHHS and accompanied by supporting documentation specified by EOHHS;

2) The Contractor shall follow all policies and procedures specified by EOHHS relating to such request, including but not limited to the following:

a) The Contractor shall take all serious and reasonable efforts specified by EOHHS prior to making the request. Such efforts include, but are not limited to:

(i) attempting to provide Medically Necessary ACO Covered Services to the particular Enrollee through at least three PCPs or other relevant Network Providers that:

(a) Meet the access requirements specified in **Section 2.9.B** for the relevant provider type; and

(b) Are critical for providing ongoing or acute ACO Covered Services, including Behavioral Health Services and other specialty services required under this Contract, to meet the Enrollee's needs;

(ii) attempting to provide all resources routinely used by the Contractor to meet Enrollees' needs, including but not limited to, Behavioral Health Services and Care Management;

b) The Contractor shall include with any request the information and supporting documentation specified by EOHHS, including demonstrating that the Contractor took the serious and reasonable efforts specified by EOHHS and, despite such efforts, the Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either the particular Enrollee or other Enrollees; and

c) The Contractor shall provide all EOHHS-specified notices to the Enrollee relating to the request.

c. EOHHS reserves the right, at its sole discretion, to determine when and if a Contractor's request to terminate the enrollment of an Enrollee will be granted based on the criteria in **Section 3.3.C** above. In addition, if EOHHS determines that the Contractor too frequently requests termination of enrollment for Enrollees, EOHHS reserves the right to deny such requests and require the Contractor to initiate corrective action to improve the Contractor's ability to serve such Enrollees.

3. The Contractor shall notify EOHHS within 10 business days when an Enrollee enters a state school for the mentally retarded, a state psychiatric hospital, or a locked DYS facility; such notice shall include the date of admission to such facility and shall be in a form and format approved by EOHHS.

E. PCP Selection, Assignment, Transfers and Responsibilities

1. PCP Selection

The Contractor shall:

a. Allow each Enrollee to choose his or her PCP and other health care professionals to the extent possible and appropriate;

b. Make its best efforts to assist and encourage each Enrollee to select a PCP. Such best efforts shall include, but not be limited to, providing interpreter services where necessary to assist the Enrollee in choosing a PCP, making efforts to contact those Enrollees who have not contacted the Contractor and, in the case of children in the care or custody of DCF or youth affiliated with DYS (either detained or committed), making efforts to contact the child's state caseworker through the EOHHS-appointed DCF or DYS liaison (see **Section 2.6.F.3**); and

c. Assist Enrollees in selecting a PCP, within 15 days after their Effective Date of Enrollment, by eliciting information on prior PCP affiliations that the Enrollee may have had and providing the Enrollee with relevant information on PCPs in close proximity to the Enrollee, including providing information regarding the experience of the PCP in treating special populations, for example, homeless persons, individuals with disabilities, and children in the care or custody of DCF or youth affiliated with DYS (either detained or committed).

2. PCP Assignment

a. In the event that the Contractor is unable to elicit a PCP selection from an Enrollee, the Contractor shall promptly assign a PCP to each such Enrollee as described below. Such assignment shall be to the most appropriate PCP in accordance with this Contract and EOHHS policies and shall be effective no later than 15 days after the Effective Date of Enrollment in the Contractor's Plan.

b. The Contractor shall, at a minimum, determine whether the assigned Enrollee has received services under the Contractor's Plan within the previous year under MassHealth or a commercial membership.

1) If the assigned Enrollee was previously enrolled with the Contractor's Plan, then the assignment shall be to the Enrollee's most recent PCP if, in the Contractor's reasonable judgment, such assignment is appropriate.

2) If the assigned Enrollee was not previously enrolled with the Contractor's Plan, then the Contractor shall make its best efforts to seek and obtain pertinent information from the Enrollee to assign the Enrollee to an appropriate PCP, considering all sources of information available to the Contractor, including but not limited to, information provided by EOHHS or its CSC Enrollment Vendor. The Contractor shall, based on such information that it is able to obtain in a timely manner, take into account factors that include, but are not limited to, the following:

a) Available information on the Enrollee's health care needs, including Behavioral Health Services needs;

b) PCP training and expertise with demographic or special populations similar to the Enrollee, including children in the care or custody of DCF or youth affiliated with DYS (either detained or committed) and homeless persons;

c) Geographical proximity of PCP site(s) to the Enrollee's residence;

d) Whether the PCP site is accessible by public transportation;

e) Whether the PCP site is accessible to people with disabilities;

f) The Enrollee's preferred language and capabilities of the PCP to practice in that language; and

g) Access to skilled medical interpreters who speak the Enrollee's preferred language at the PCP site.

c. The Contractor shall inform the Enrollee of the name of the PCP to whom he or she is assigned and offer to assist the Enrollee in scheduling an initial appointment with the PCP.

d. The Contractor shall routinely and promptly inform PCPs of newly assigned Enrollees and shall require PCPs to make best efforts to schedule an initial appointment with new Enrollees.

e. The Contractor shall submit to EOHHS for its review and prior approval, a model assignment notification letter for Enrollees and an assignment notice for PCPs.

f. For any Enrollee who has not yet selected or been assigned a PCP, the Contractor shall, within three business days after receiving notification that such Enrollee seeks to or has obtained care, in or out of the Contractor's Provider Network, contact the Enrollee and assist the Enrollee in choosing a PCP. If the Contractor is unable to reach the Enrollee, then the Contractor shall assign a PCP to such Enrollee and affirmatively notify the Enrollee of the assignment.

3. PCP Transfers

The Contractor shall:

a. At the Enrollee's request, allow the Enrollee to change his or her PCP with or without cause. Enrollment with the new PCP shall be effective the next business day;

b. Monitor Enrollees' voluntary changes in PCPs to identify PCPs with higher relative rates of Enrollee disenrollment, and identify and address any opportunities for Provider education, training, quality improvement, or sanction; and

c. Annually report to EOHHS on the results of the monitoring efforts described in **Section 2.4.E.3.b** above and **Section 2.7.E.8**, and the actions taken by the Contractor.

d. Involuntary Changes in PCPs

1) The Contractor shall not involuntarily, or without the Enrollee's request, transfer an Enrollee from their current PCP to a new PCP because of

a) an adverse change in the Enrollee's health status;

b) the Enrollee's utilization of medical services, including but not limited to the Enrollee making treatment decisions with which a provider, including the PCP, or the Contractor disagrees (such as declining treatment or diagnostic testing);

c) missed appointments by the Enrollee;

d) the Enrollee's diminished mental capacity, or

e) the Enrollee's uncooperative or disruptive behavior resulting from his or her special needs (except when the Enrollee's continued enrollment with the PCP seriously impairs the PCP's ability to furnish services to either the particular Enrollee or other Enrollees)

2) The Contractor may involuntarily transfer an Enrollee from their current PCP to a new PCP if the Contractor follows all policies and procedures specified by EOHHS relating to such transfer, including but not limited to the following:

a) The Contractor shall, and shall require the PCPs to, take all serious and reasonable efforts specified by EOHHS prior to such a transfer;

b) The Contractor shall require the PCP to include with any request the PCP makes to the Contractor to transfer an Enrollee the information and supporting documentation specified by EOHHS, including demonstrating that the PCP took the serious and reasonable efforts specified by EOHHS and, despite such efforts, the Enrollee's continued

enrollment with the PCP seriously impairs the PCP's ability to furnish services to either the particular Enrollee or other Enrollees;

c) The Contractor shall provide all EOHHS-specified notices to the Enrollee relating to the request;

d) The Enrollee's new PCP to which the Contractor transfers the Enrollee must be within the access and availability requirements set forth in Section 2.9; and

e) The Contractor shall report to EOHHS, in a form and format specified by EOHHS, any involuntary transfer in accordance with **Appendix A**.

4. The Contractor shall monitor, on an ongoing basis, the completeness and accuracy of Enrollee/PCP designations. The Contractor shall:

a. Annually, and at other frequencies specified by EOHHS, audit Enrollee/PCP designations to identify Enrollees with no PCP designation or an incorrect PCP designation;

b. Take steps to rectify identified errors and gaps in Enrollee/PCP designations, such as through reconciliation of information provided by the Enrollee, the PCP, and/or the Contractor's records, and facilitation of Enrollee selection of a PCP, or assignment of Enrollees to PCPs;

c. Conduct root cause analyses, and implement activities to maximize proactively the completeness and accuracy of PCP designations;

d. Annually report to EOHHS on the results of monitoring efforts described in 4a- 4.c. above and the actions taken by the Contractor; and

e. Submit to EOHHS a Member-PCP assignment report, as described in **Appendix A**, in a format and frequency to be specified by EOHHS.

5. PCP Coordination with Behavioral Health Providers

The Contractor shall implement a plan to facilitate communication and coordination of Enrollee mental health, substance use disorders, and medical care between the Behavioral Health Provider, and the Enrollee's PCP. The plan shall, at a minimum, include policies and procedures that meet the following requirements:

a. Instruct Behavioral Health Providers on how to obtain the Enrollee's PCP name and telephone number;

b. Ensure that the PCP and the Behavioral Health Provider communicate and coordinate the Enrollee's care; and

c. Ensure that the PCP has access to Behavioral Health service resources including CBHI, substance use disorder services, community support program services, and emergency service program services.

F. Enrollee Outreach, Orientation, and Education

The Contractor shall:

1. For each Enrollee who has not been enrolled in the Contractor's Plan in the past twelve months, offer the Enrollee, and make best efforts to provide the Enrollee, an orientation, by telephone or in person, within 30 days of the Enrollee's Effective Date of Enrollment. The Contractor shall submit to EOHHS for review and approval, its outreach materials and phone scripts. Such orientation shall include, at a minimum:

   a. How MCOs operate, including the role of the PCP;

   b. If applicable, how MCO-Administered ACOs work, including the role of the PCP;

   c. The name of, and customer service telephone number for, all Material Subcontractors that provide MCO Covered Services to Enrollees, unless the Contractor retains all customer service functions for such MCO Covered Services;

   d. MCO Covered Services, limitations, and any Non-Medical Programs and Services offered by the Contractor;

   e. The value of screening and preventive care; and

   f. How to obtain services, including:

      1) Emergency Services for physical and behavioral health;

      2) Accessing OB/GYN and specialty care;

      3) Behavioral Health Services;

      4) Disease Management programs;

      5) Care Management;

      6) Early Intervention Services;

      7) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, including well-child care and screenings according to the EPSDT Periodicity Schedule;

      8) Smoking cessation services; and

9) Wellness programs.

2. The Contractor must provide a range of health promotion and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall:

a. Implement innovative Enrollee education strategies for wellness care and immunizations, as well as general health promotion and prevention, and behavioral health rehabilitation and recovery;

b. Work with Network PCPs and Network Provider specialists, as appropriate, to integrate health education, wellness and prevention training into the care of each Enrollee;

c. Participate in any EOHHS-led joint planning activities with MassHealth-contracted Accountable Care Partnership Plans and MassHealth-contracted MCOs to develop and implement statewide or regional approaches to Enrollee health and wellness education;

d. Provide condition and disease-specific information and educational materials to Enrollees, including information on its Care Management and Disease Management programs described in **Section 2.5**. Condition and disease specific information must be oriented to various groups within the MassHealth Managed Care eligible population, including but not limited to:

1) Enrollees with Special Health Care Needs;

2) Homeless Enrollees;

3) Limited English-speaking Enrollees;

4) Children in the care or custody of DCF or youth affiliated with DYS (either detained or committed);

5) Adults who are seriously and persistently mentally ill;

6) Children with Serious Emotional Disturbance;

7) Enrollees with active/advanced AIDS as further defined by EOHHS;

8) Enrollees with severe physical disabilities as further defined by EOHHS;

9) Pregnant individuals with substance use disorders; and

10) Adults with Co-Occurring Disorders;

e. Submit all proposed health promotion and wellness information, activities, and material to EOHHS for approval prior to distribution. The Contractor shall submit such

information, activities, and material to EOHHS for approval at least 30 days prior to distribution;

3. Member Education and Related Enrollment Materials

   a. The Contractor shall provide to EOHHS, for review and approval, any changes to the information specified below. For such changes, the Contractor shall make revisions or amendments to Enrollee materials and/or CSC training materials previously submitted to EOHHS and shall include such revised or amended materials in its submission to EOHHS in a manner that allows EOHHS to easily identify the Contractor's revisions or amendments:

      1) Changes, including additions and deletions, to the Contractor's Provider Network from the Contractor's most recently printed Provider directory (or directories), described in **Section 2.7.E**;

      2) Changes in the Contractor's Non-Medical Programs and Services offered to Enrollees, including but not limited to, fitness and educational programs in accordance with **Section 2.6.A.9 and 10**;

      3) Changes in the Contractor's procedures and policies which affect the process by which Enrollees receive care;

      4) Changes in the Contractor's orientation and educational materials in compliance with **Section 2.4.F**;

      5) Changes requested in EOHHS's enrollment materials as a result of the changes described in **paragraphs a.-d**. above; and

      6) Any other significant change that impacts Enrollees.

   b. The Contractor shall provide EOHHS with additional updates and materials that, at its discretion, EOHHS may reasonably request for purposes of providing information to assist Members in selecting a health plan, or to assist EOHHS in assigning a Member who does not make a selection.

4. The Contractor shall ensure, in accordance with 42 USC §1396u-2(a)(5), that all written information for use by Enrollees and Potential Enrollees is prepared in a format and manner that is easily readable, comprehensible to its intended audience, well designed, and includes a card instructing the Enrollee in multiple languages that the information affects their health benefit, and to contact the Contractor's Plan for assistance with translation.

5. On a monthly basis, the Contractor shall notify EOHHS of all Enrollees whom the Contractor has been unable to contact as a result of undeliverable mail and an incorrect telephone number. Such notification shall be in the format and process specified by EOHHS in consultation with the Contractor.

Section 2.5 Care Delivery, Care Coordination, and Care Management

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

A. General Care Delivery Requirements

In accordance with all other applicable Contractor requirements, the Contractor shall ensure that all Enrollees receive care that is timely, accessible, and Linguistically and Culturally Competent. The Contractor shall:

1. Ensure that all Enrollees may access:

    a. Primary Care or Urgent Care during extended hours;

    b. Same-day appointments for certain services;

    c. Medical and diagnostic equipment that is accessible to Enrollees;

    d. Care that is Linguistically and Culturally Competent. The Contractor shall regularly evaluate the population of Enrollees to identify language needs, including needs experienced by Enrollees who are deaf or hard of hearing, and needs related to health literacy, and to identify needs related to cultural appropriateness of care (including through the Care Needs Screening as described in **Section 2.5.B**). The Contractor shall identify opportunities to improve the availability of fluent staff or skilled translation services in Enrollees' preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care;

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

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

3. Coordinate transportation to medical appointments where Medically Necessary for the Enrollee to access medical care;

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

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

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

    a. Intensive Care Coordination;

    b. Family Support and Training Services;

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

    d. Therapeutic Mentoring Services;

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

    f. Youth Mobile Crisis Intervention Services (MCI);

7. Ensure that all Enrollees have access to Emergency Behavioral Health services, including immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week;

8. Follow up with an Enrollee within 24 hours of when the Enrollee accesses emergency behavioral health services, including ESP and Mobile Crisis Intervention services;

9. Develop, implement, and maintain Wellness Initiatives as follows and as further directed by EOHHS:

    a. Such Wellness Initiatives shall include, but are not limited to, programs such as:

        1) General health education classes, including how to access appropriate levels of health care;

        2) Tobacco cessation programs, with targeted outreach for adolescents and pregnant individuals;

        3) Childbirth education classes;

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

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

6) Early detection of mental health issues in children;

7) Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;

8) Chronic disease self-management;

9) Prevention and treatment of alcohol and substance use disorders;

10) Coping with losses resulting from disability or aging;

11) Self-care training, including self-examination; and

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

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

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

10. Develop, implement, and maintain Disease Management programs as follows and as further directed by EOHHS:

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

b. The Contractor shall utilize information resulting from its risk stratification processes described in **Section 2.5.H.2** to inform the development of Disease Management programs;

c. Such programs shall include activities such as but not limited to:

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

2) Outreach to Enrollees to encourage participation in the appropriate level of care and Care Management for their disease or condition;

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

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

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

6) The Care Management activities described in **Section 2.5.E**.

11. Establish such affiliations with providers (including Community Service Agencies (CSAs) in the Contractor's geographic area, as determined by EOHHS) and organizations as necessary to fulfil the requirements of this Section, including affiliations with Community Partners and other community-based organizations and social services organizations;

12. Ensure appropriate care for Enrollees with Special Health Care Needs.

13. Make best efforts to minimize boarding of Enrollees in emergency departments as follows:

a. The Contractor shall ensure timely access to medically necessary, clinically appropriate Behavioral Health Services for Enrollees determined by EOHHS to be disproportionately boarded in emergency departments, including, but not limited to, Enrollees with:

1) Autism Spectrum Disorder (ASD);

2) Intellectual or Developmental Disabilities (IDD);

3) Dual diagnosis of mental health and substance use disorder;

4) Co-morbid medical conditions; and

5) Assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric hospital setting; and

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

B. Care Needs Screening and Appropriate Follow-Up

The Contractor shall ensure that Enrollees receive screenings to identify their health and functional needs as follows:

1. The Contractor shall develop, implement, and maintain procedures for completing, an initial Care Needs Screening for each Enrollee, and shall make best efforts to complete such screening within 90 days of the Enrollee's Effective Date of Enrollment, including making subsequent attempts if the initial attempt to contact the Enrollee is unsuccessful;

2. The Contractor's Care Needs Screening shall:

    a. Be a survey-based instrument approved by EOHHS;

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

    c. Be conducted with the consent of the Enrollee;

    d. Include disclosures of how information will be used;

    e. In addition to the other requirements of this Section, incorporate, at a minimum:

        1) The National Committee for Quality Assurance (NCQA) Member Connections (MEM) 1 Health Appraisals Element A standards including but not limited to questions on member demographics, personal health history, including chronic illness and current treatment; and self-perceived health status;

        2) Questions to identify Enrollees with Special Health Care Needs;

        3) Questions to identify Enrollees' needs for Culturally and Linguistically Appropriate Services including but not limited to hearing and vision impairment and language preference;

        4) Questions to identify Enrollees' needs for accessible medical and diagnostic equipment;

        5) Questions to identify the Enrollee's health concerns and goals; and

        6) Questions that specifically screen for care needs experienced by children, including evaluating characteristics of the Enrollees' families and homes;

    f. As further directed by EOHHS, evaluate Enrollees' needs for Behavioral Health-related services, including unmet needs and including Enrollees' appropriateness for assignment to BH CPs as further specified by EOHHS. Contractor's Care Needs Screening shall evaluate characteristics such as but not limited to:

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

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

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

4) The Enrollee's affiliation with any state agency that provides BH-related care management or other activities, including the Department of Mental Health (DMH) and the Bureau of Substance Abuse Services (BSAS);

g. As further directed by EOHHS, evaluate Enrollees' needs for LTSS and LTSS-related services, including unmet needs and including Enrollees' appropriateness for assignment to LTSS CPs as further specified by EOHHS. The Contractor's Care Needs Screening shall evaluate characteristics such as, but not limited to:

1) Current use of MassHealth services that could be reasonably viewed as LTSS, such as:

a) Adult Day Health Services;

b) Adult Foster Care Services;

c) Continuous Skilled Nursing Services (post-100 days of services);

d) Day Habilitation Services;

e) Group Adult Foster Care Services;

f) Nursing Facility Services (post-100 days of services);

g) Inpatient and Outpatient Chronic Disease Rehabilitation Hospital Services (post-100 days of services); and

h) Personal Care Attendant Services (including Transitional Living Program).

2) Participation in a Home and Community Based Services (HCBS) Waiver;

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

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

5) Risk for institutionalization;

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

7) Whether the Enrollee currently is the only adult in their home environment.

h. As further directed by EOHHS, evaluate Enrollees' health-related social needs, including whether the Enrollee would benefit from receiving community services to address health-related social needs. Such services shall include but not be limited to:

1) Housing stabilization and support services;

2) Housing search and placement;

3) Utility assistance;

4) Physical activity and nutrition; and

5) Support for Enrollees who have experience of violence.

i. Evaluate Enrollees' needs for care that is Culturally and Linguistically Competent, including identifying Enrollees' preferred languages;

j. Evaluate whether an Enrollee is an Enrollee with Special Health Care Needs; and

k. Otherwise identify an Enrollee's risk factors and relevant health and functional needs, as further directed by EOHHS.

3. The Contractor shall otherwise evaluate Enrollees' needs through means other than the Care Needs Screenings. Such means shall include but not be limited to regular analysis of available claims, Encounter Data, and clinical data on Enrollees' diagnoses and patterns of care;

4. The Contractor shall ensure that Enrollees receive Medically Necessary and appropriate care and follow-up based on their identified needs through any assessment or screening, including but not limited to those performed pursuant to this Section. The Contractor shall:

a. For Enrollees with identified LTSS- or BH-related needs, coordinate as appropriate with the Contractor's CPs to fulfil the requirements of this Section, as described in **Sections 2.5.F and 2.5.G;**

b. Ensure that Enrollees who are identified as having care needs as described in this Section receive assistance in accessing services to meet those needs. Such assistance shall include activities such as but not limited to:

1) Referring the Enrollee to providers, social service agencies, or other community-based organizations that address the Enrollee's needs, including but not limited to Medically Necessary services;

2) Providing the Enrollee with support to ensure a successful referral, including:

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

b) The Enrollee's PCP communicating and sharing records with the provider being referred to, as appropriate to coordinate care; and

c) The Enrollee's PCP directly introducing the Enrollee to the service provider, if co-located, during a medical visit (i.e., a "warm hand-off").

3) Providing information and navigation to the Enrollee regarding community providers of social services that address the Enrollee's health-related social needs, as appropriate;

4) Providing the Enrollee with information and providing impartial counseling about available options;

5) Coordinating with service providers and state agencies to improve integration of Enrollees' care; and

6) Facilitating the transition of an Enrollee to a different level of care, setting of care, frequency of care, or provider, to better match care to the Enrollee's indicated needs;

c. Ensure that Enrollees with Special Health Care Needs are comprehensively assessed and receive a Care Plan, as described in **Section 2.5.D**;

d. Contractor shall develop, implement, and maintain policies and procedures regarding the identification of, outreach to, and assessment of Enrollees with Special Health Care Needs within the required timeframe specified in **Section 2.5.D;**

e. Ensure that Enrollees with identified LTSS needs receive appropriate services and referrals to address their care needs, which may include for certain Enrollees referral to an LTSS CP or otherwise being comprehensively assessed and receiving a Care Plan, as described in **Section 2.5;**

f. Ensure that BH and LTSS CP Assigned Enrollees receive a Comprehensive Assessment and a Care Plan, as described in **Section 2.5;**

g. Ensure that all Enrollees with significant BH needs, as further defined by EOHHS, receive appropriate services to address their care needs, as follows:

1) The Contractor shall:

a) Ensure all such Enrollees receive appropriate services and referrals to address their care needs, which may include for certain Enrollees referral to a BH CP, as described in **Section 2.5.D**;

b) Work with Contractor's BH CPs to assist such Enrollees with in accessing appropriate services, including but not limited to providing navigation and referral, as described in **Section 2.5.F**;

c) Ensure that providers utilize a Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for Enrollees, as appropriate and as further specified by EOHHS;

d) Record in each such Enrollee's medical record appropriate information on the Enrollee's access to care, including but not limited to information on whether each Enrollee has a Comprehensive Assessment, a Care Plan, a Care Coordinator or Clinical Care Manager assigned to their care, and sufficient access to ongoing support and treatment that meets the Enrollee's care needs;

e) Report to EOHHS on such information and on Contractor's success in connecting such Enrollees to appropriate levels of care, in aggregate form or as further directed by EOHHS; and

f) Ensure that each such Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, as applicable;

2) Such services shall include but not be limited to services such as:

a) Behavioral health services including inpatient, diversionary, and outpatient care;

b) Substance use disorder treatment;

c) Peer Supports, recovery coaches, and self-help groups;

d) For Enrollees under the age of 21, services under the Children's Behavioral Health Initiative;

e) Community Support Program (CSP) services, including but not limited to CSP services for the chronically homeless; and

f) Services provided by other state agencies, including but not limited to DMH, DDS, DCF, and DYS;

h. The Contractor shall ensure that certain Enrollees receive BH clinical assessment and treatment planning as described in **Section 2.8.D**;

5. To prevent duplication of activities relating to identifying and assessing an Enrollee's needs, share any such identification and assessment of needs conducted by the Contractor with EOHHS, as requested and in a form and format specified by EOHHS.

C. Care Coordination, Transitional Care Management, and Clinical Advice and Support Line

The Contractor shall ensure that care for all Enrollees is coordinated. The Contractor shall, at a

minimum, as described in this Section and further specified by EOHHS, perform care coordination activities for Enrollees; have a Transitional Care Management program to coordinate Enrollees' care during transitions such as hospital discharges; and maintain a Clinical Advice and Support Line to provide Enrollees access to information and assistance that supports coordinated care.

1. The Contractor shall perform care coordination activities for Enrollees as follows. The Contractor shall:

    a. For Enrollees with identified LTSS- or BH-related needs, coordinate with Contractor's CPs as appropriate to fulfil the requirements of this Section, as described in this Section and in **Sections 2.5.F and 2.5.G**;

    b. Coordinate care for all Enrollees, including but not limited to:

        1) Assisting Enrollees to navigate to and access Medically Necessary services;

        2) Facilitating communication between the Enrollee and the Enrollee's providers and among such providers, for example, through the use of the Mass HIway;

        3) Monitoring the provision of services, making necessary referrals and assessing Enrollees for needed changes in services, in accordance with **Section 2.6.D**; and

        4) Coordinating with staff in other state agencies, or community service organizations, if the agency/organization is already involved in serving the Enrollee, or providing information and referral if the agency/organization may be helpful in meeting such needs;

    c. Ensure that all Enrollees receive information about how to contact the Contractor to access care coordination; and

    d. Ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, as applicable.

2. The Contractor shall have a Transitional Care Management program. The Contractor shall develop, implement, and maintain protocols for Transitional Care Management with all Network hospitals. Such protocols shall:

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

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

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

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

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

1) Event notification protocols that ensure key providers and individuals involved in an Enrollee's care are notified of admission, transfer, discharge, and other important care events, for example, through the use of the Mass HIway and the Mass HIway Event Notification Service (ENS). Such key providers shall include but not be limited to an Enrollee's PCP, BH provider if any, and LTSS provider (e.g., Personal Care Attendant) if any;

2) Medication reconciliation;

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

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

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

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

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

g. Take into account the requirements for Network Provider contracts with hospitals as described in **Section 2.7.C.3.b**.

3. The Contractor shall maintain a Clinical Advice and Support Line, accessible by Enrollees 24 hours a day, seven days a week, in accordance with the following:

a. The Clinical Advice and Support Line shall:

1) Be easily accessible to Enrollees. The Clinical Advice and Support Line shall:

a) Have a dedicated toll-free telephone number;

b) Offer all services in all prevalent languages, at a minimum;

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

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

2) Provide access to medical advice as follows:

a) The Clinical Advice and Support Line shall be staffed by a registered nurse or similarly licensed and qualified clinician, and shall provide direct access to such clinician;

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

c) The Clinical Advice and Support Line shall have documented protocols for determining an Enrollee's acuity and need for emergent, urgent, or elective follow-up care, and for when the Enrollee should go to the emergency room versus an urgent care center, if it is available, versus advising the Enrollee to call his or her PCC the following business day and schedule an appointment;

3) Facilitate coordination of Enrollee care as follows:

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

(i) Processes and capabilities to identify an Enrollee who calls the Clinical Advice and Support Line;

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

(iii) The name and contact information of the Enrollee's Care Coordinator or Clinical Care Manager, if applicable;

b) The Clinical Advice and Support Line shall be incorporated in the Contractor's policies and procedures for care coordination and Care Management, such as policies and procedures for:

(i) The Clinical Advice and Support Line notifying Providers and Care Management staff involved in an Enrollee's care of a phone call, particularly if the call indicates a need to modify the Enrollee's documented Care Plan or course of treatment or a need for follow-up;

(ii) The Clinical Advice and Support Line's clinicians being able to access relevant information from an Enrollee's Care Plan or medical record under certain circumstances to respond to an Enrollee's questions and coordinate care; and

(iii) The Clinical Advice and Support Line providing appropriate information and navigation to Enrollees to Providers who can support an Enrollee's needs, including but not limited to Network Providers and providers involved in an Enrollee's care;

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

4) Provide general health information to Enrollees and answer general health and wellness-related questions;

4. The Contractor shall implement policies and procedures that ensure timely, appropriate, and comprehensive Discharge Planning for Enrollees who are homeless or at risk of homelessness as further specified by EOHHS.

D. Assessment and Member-Centered Care Planning

The Contractor shall ensure that certain Enrollees, as described in this Section and further specified by EOHHS, are comprehensively assessed and receive a documented Care Plan that is informed by such assessment. Such assessment and documented Care Plan shall be member-centered and shall inform Enrollees' care, including but not limited to any Care Management activities, as described in this Section and further specified by EOHHS.

1. The Contractor shall comprehensively assess certain Enrollees as follows:

a. The Contractor shall either directly or, as appropriate, through its Community Partners or MCO-Administered ACOs, comprehensively assess:

1) LTSS-CP Assigned Enrollees;

2) BH CP-Assigned Enrollees. For any such BH CP-Assigned Enrollees, the Contractor shall obligate the Contractor's BH CP to comprehensively assess such Enrollees; and

3) Enrollees with Special Health Care Needs;

b. The Contractor shall ensure that Enrollees are comprehensively assessed using a person-centered assessment of an Enrollee's care needs and, as applicable and

clinically appropriate, the Enrollee's functional needs, accessibility needs, goals, and other characteristics, taking into consideration the domains listed in **Section 2.5.D.1.l.2.**

c. The Contractor shall ensure that BH and LTSS CP-Assigned Enrollees are comprehensively assessed within 90 days of the effective date of each such Enrollee's assignment to a BH or LTSS CP;

d. The Contractor shall ensure that Enrollees with Special Health Care Needs are comprehensively assessed within 180 days of their enrollment date in Contract Year 1, and the Contractor shall ensure that Enrollees with Special Health Care Needs enrolled in each subsequent year shall be comprehensively assessed within 90 days of enrollment;

e. The Contractor shall update such assessments

1) at least annually thereafter, and

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

f. The Contractor shall record such assessments in Enrollees' medical records;

g. Such assessments shall be performed using assessment tools and methods as approved by EOHHS;

h. The Contractor shall otherwise ensure that the assessment is completed independently, by an individual who is not financially or otherwise conflicted, as further defined by EOHHS;

i. The Contractor shall respond to requests by EOHHS or EOHSS' designee (e.g., EOHHS' Third Party Administrator (TPA)) for copies of the assessments of Enrollees seeking Long Term Services and Supports as follows and as further specified by EOHHS:

1) For such an Enrollee for whom such an assessment has been completed, the Contractor shall provide a copy of the assessment as specified by EOHHS;

2) For such an Enrollee for whom no assessment has been completed, the Contractor shall provide the Enrollee's Care Needs Screening information or other information as specified by EOHHS; and

3) The Contractor shall designate an individual to receive such requests and shall supply contact information for that individual to EOHHS;

j. As further directed by EOHHS, the Contractor may, where appropriate, meet the assessment requirement, as described in **Section 2.5.D**, with an existing assessment for an Enrollee rather than conducting a new assessment, where such existing assessment is timely and appropriate, as further defined by EOHHS;

k. As requested by EOHHS, the Contractor shall report, in a form and format as specified by EOHHS, about assessments in accordance with **Appendix A**.

l. Comprehensive Assessments for BH and LTSS CP-Assigned Enrollees

1) The Contractor shall provide, either directly or, as appropriate through its Community Partners, a Comprehensive Assessment, as further specified by EOHHS, to BH-CP Assigned Enrollees and LTSS-CP Assigned Enrollees;

2) Comprehensive Assessments, as provided to BH and LTSS CP-Assigned Enrollees, shall include domains and considerations appropriate for the population receiving the Comprehensive Assessment, as further specified by EOHHS, and shall include, but may not be limited to, the following domains and considerations, as they relate to the Enrollee:

a) Immediate care needs and current services, including but not limited to any care coordination or management activities and any services being provided by state agencies such as DMH, DDS, MRC, MCB, DCF, DYS, or EOEA;

b) Health conditions;

c) Medications;

d) Ability to communicate their concerns, symptoms, or care goals;

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

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

g) Current and past mental health and substance use;

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

i) Housing and home environment, including but not limited to risk of homelessness, housing preferences, and safety;

j) Employment status, interests, and goals, as well as current use of and goals for leisure time;

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

l) Risk factors for abuse or neglect;

m) Food security, nutrition, wellness, and exercise;

n) Advance directives status and preferences and guardianship status; and

o) Other domains and considerations identified by EOHHS;

3) EOHHS may specify such Comprehensive Assessment tool, at EOHHS' discretion;

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

5) Such Comprehensive Assessments shall incorporate an assessment of the Enrollee's functional needs for LTSS, as further specified by EOHHS;

m. Unless clinically appropriate, a new Comprehensive Assessment shall not be conducted for an Enrollee when a Comprehensive Assessment has been conducted for that Enrollee within the last calendar year and includes all domains and considerations described in **Section 2.5.D.1.l.2**.

2. The Contractor shall provide Enrollees with documented Care Plans as follows:

a. The Contractor shall, at a minimum, provide, either directly or, as appropriate, through its Community Partners or MCO-Administered ACOs, documented Care Plans to:

1) LTSS CP-Assigned Enrollees. For any such LTSS-Assigned Enrollees, the Contractor shall obligate the Contractor's LTSS CPs to complete the LTSS component of such Care Plan;

2) BH CP-Assigned Enrollees. For any such BH CP-Assigned Enrollees, the Contractor shall obligate the Contractor's BH CPs to provide such Care Plans; and

3) Enrollees with Special Health Care Needs;

b. As requested by EOHHS, the Contractor shall report, in a form and format as specified by EOHHS, about Care Plans in accordance with **Appendix A**.

c. Care Plans shall be developed in accordance with any applicable EOHHS quality assurance and utilization review standards.

d. Care Plans for LTSS CP-Assigned Enrollees and BHCP-Assigned Enrollees shall:

1) Be unique to each Enrollee;

2) Be in writing;

3) Reflect the results of the Enrollee's Comprehensive Assessment, or other approved assessment as described in **Section 2.5.D.1.l;**

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

5) Be signed or otherwise approved by the Enrollee. The Contractor shall establish and maintain policies and procedures to ensure an Enrollee can sign or otherwise convey approval of his or her Care Plan when it is developed or subsequently modified. Such policies and procedures shall include;

a) Informing an Enrollee of his or her right to approve the Care Plan;

b) Providing mechanisms for the Enrollee to sign or otherwise convey approval of the Care Plan. Such mechanisms shall meet the Enrollees accessibility needs;

c) Documenting the Enrollee's verbal approval of the Care Plan, including a description of the accommodation need that does not permit the Enrollee to sign the Care Plan, in the medical record. In the absence of an accommodation need, the reason a signature was not obtainable shall be documented and a signature from the Enrollee shall be obtained within three (3) months of the verbal approval;

d) Providing the Enrollee with a copy of the approved and signed Care Plan in an appropriate and accessible format, as indicated by the Enrollee's accommodation needs and including but not limited to alternative methods or formats and translation into the primary language of the Enrollee (or authorized representative, if any);

e) Informing an Enrollee of his or her right to an Appeal of any denial, termination, suspension, or reduction in services, or any other change in providers, services, or medications included in the Care Plan; and

f) Informing an Enrollee of the availability of and access to Ombudsman services in accordance with **Section 2.12.B.8**.

6) Be approved and signed by the Enrollee's PCP or PCP Designee in a timely manner, as further specified by EOHHS. Such approval shall include, but shall not be limited to, approval of Care Plans completed by the Contractor, Care Plans completed by the Contractor's BH CPs and approval of the LTSS component of Care Plans completed by the Contractor's LTSS CPs, as further specified by EOHHS.

7) Be completed using a template approved by EOHHS, and include at a minimum, the following information:

a) Certain information on the first page or in a cover sheet, as further specified by EOHHS;

b) Name and contact information for

(i) Care coordinator(s),

(ii) PCP or PCP Designee, and

(iii) Additional care team members, as applicable;

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

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

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

f) Recommended action step for each goal with associated responsible care team member and any related accessibility requirements;

g) Identification of barriers to meeting goals;

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

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

j) Back-up or contingency plan; and

k) Documentation of Enrollee and PCP or PCP Designee signature and date.

8) Be completed, including being signed or otherwise approved by the Enrollee and signed by the Enrollee's PCP or PCP Designee, within five (5) calendar months of the Enrollee's Assignment to the Enrollee's BH CP or LTSS CP.

9) Be updated annually as follows:

a) Annual updates shall be informed by the annual Comprehensive Assessment;

b) Annual updates shall be signed or otherwise approved by the Enrollee and approved and signed by the Enrollee's PCP or PCP Designee within one (1) year of PCP or PCP Designee signature on the previous Care Plan; and

c) The development of the annual updates shall include at a minimum the following activities:

(i) Determining the Enrollee's progress toward goals;

(ii) Reassessing the Enrollee's health status;

(iii) Reassessing the Enrollee's goals;

(iv) Monitoring the Enrollee's compliance with the Care Plan;

(v) Documenting recommendations for follow-up; and

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

10) In addition to being annually updated in accordance with Section **2.5.D.2.d.9**, be updated as follows:

a) Following transitions of care, and when a change in the Enrollee's health status has occurred that is due to progressive disease, functional decline, or resolution of a problem or condition that represents a consistent pattern of changes that is not self-limiting; impacts more than one area of the Engaged Enrollee's health status; and requires a review by the Care Team.

b) Such updates to Care Plans shall be signed or otherwise approved by the Enrollee and the PCP or PCP Designee shall be notified of the update; and

c) Such updates shall include at a minimum one of the activities described in **2.5.D.2.d.9.c**.

11) For Care Plans for LTSS-CP Assigned Enrollees only:

a) Such Care Plan shall include services and supports to meet LTSS and social service needs.

b) The Contractor shall integrate the LTSS component of the Care Plan completed by the LTSS CP into the Care Plan for LTSS CP-Assigned Enrollees completed by the Contractor pursuant to **Section 2.5.D.2.d.**

e. Contractor's staff preparing Care Plans shall complete trainings related to the CP Program, as further specified by EOHHS.

f. Care Plans for Enrollees with Special Health Care Needs shall:

1) Be based on an Enrollee's approved assessment as described in **Section 2.3.D.1**, and developed under the direction of the Enrollee (or the Enrollee's representative, if applicable);

2) Reflect the Enrollee's preference and needs;

3) Be updated at least every 12 months, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee. The Enrollee shall be at the center of the care planning process;

4) Designate the Enrollee's care team, as applicable, including participants of the Enrollee's choosing;

5) Be signed or otherwise approved by the Enrollee. The Contractor shall establish and maintain policies and procedures to ensure an Enrollee can sign or otherwise convey approval of his or her Care Plan when it is developed or subsequently modified. Such policies and procedures shall include:

a) Informing an Enrollee of his or her right to approve the Care Plan;

b) Providing the Enrollee with a copy of the Care Plan;

c) Providing mechanisms for the Enrollee to sign or otherwise convey approval of the Care Plan. Such mechanisms shall meet the Enrollee's accessibility needs; and

d) Informing an Enrollee of the availability of and access to Ombudsman services; and

6) Be approved and signed by the Enrollee's PCP or PCP Designee in a timely manner, as further specified by EOHHS.

E. Care Management

The Contractor shall provide Care Management activities to appropriate Enrollees as described in this Section and further specified by EOHHS.

1. The Contractor shall proactively identify Enrollees who may benefit from Care Management activities based on the results of the evaluation as described in this Section. Such evaluation shall:

    a. Explicitly incorporate, at a minimum:

        1) Enrollees with Special Health Care Needs;

        2) Enrollees with LTSS needs, as described in **Section 2.5.B.2.g**;

        3) Enrollees who are identified by EOHHS as potentially in need of or benefitting from Care Management;

        4) Enrollees who are identified by PCPs as potentially in need of or benefitting from Care Management;

        5) Enrollees who self-identify to the Contractor as potentially in need of or benefitting from Care Management; and

        6) Enrollees identified as high risk Enrollees through the risk stratification process described in **Section 2.5.H.2** or identified as high utilizers through the process described in **Section 2.6.D.10.d**.

    b. Incorporate information contained, if applicable and as available, in each Enrollee's:

        1) Care Needs Screening;

        2) Claims or encounter data;

        3) Medical records;

        4) Laboratory results;

        5) Pharmacy data;

        6) Discharge data; and

        7) Other relevant sources of information identified by the Contractor or EOHHS, including but not limited to risk stratification information;

    c. Incorporate predictive modeling of an Enrollee's risk for high cost, high utilization, admission, re-admission, or other adverse health outcomes;

2. The Contractor shall provide each such identified Enrollee with Care Management as follows:

a. Care Management shall include activities such as but not limited to:

1) Providing a Comprehensive Assessment as described in **Section 2.5.D.1** for Enrollees assigned to a BH or LTSS CP;

2) Otherwise comprehensively assessing Enrollees with Special Health Care Needs as described in **Section 2.5.D.4.c**;

3) Creating a documented Care Plan as described in **Section 2.5.D.2** and updating such Care Plan at least annually;

4) Providing a Care Coordinator or Clinical Care Manager who is assigned to the Enrollee's care;

5) Designating a care team of providers and other individuals involved in the Enrollee's care. The care team shall include, at a minimum:

a) The Enrollee's Care Coordinator or Clinical Care Manager;

b) The Enrollee's PCP;

c) The Enrollee's behavioral health provider (if applicable) or Contractor's BH CP, as appropriate;

d) The Enrollee's LTSS provider (if applicable) or Contractor's LTSS CP, as appropriate; and

e) Any additional individual requested by the Enrollee;

6) Providing team-based Care Management, including meetings of the care team at least annually and after any major events in the Enrollee's care or changes in health status, or more frequently if indicated;

b. The Contractor shall develop, implement, and maintain criteria and protocols for determining which Care Management activities may benefit an Enrollee;

c. The Contractor shall, at a minimum:

1) Provide a Care Coordinator who is assigned to the Enrollee's care for any Enrollee with Special Health Care Needs, who is a BH CP-Assigned Enrollee, or who is an LTSS CP Assigned Enrollee;

2) Provide a Clinical Care Manager who is assigned to the Enrollee's care and a documented Care Plan based on a Comprehensive Assessment, or other assessment as described in **Section 2.5.D,** for any Enrollee receiving Care

Management and identified by the Contractor or EOHHS as at risk for adverse care events; and

3) Coordinate with Contractor's BH CPs to perform outreach and engagement to any BH CP-Assigned Enrollee and to provide Care Management to any BH CP-Engaged Enrollee, as described in **Section 2.5.F**;

d. The Contractor shall develop, implement, and maintain procedures for providing, and shall provide, Care Management as follows:

1) The Contractor's Care Management procedures shall:

a) Be approved by EOHHS;

b) Include procedures for acquiring and documenting Enrollees' consent to receive Care Management and for the Contractor to share information about an Enrollee's care with Enrollees' providers to promote coordination and integration. Contractor shall make best efforts to obtain such consent;

c) Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for Care Coordinators, Clinical Care Managers, and other staff involved in Care Management activities in line with industry practices;

d) Include processes for Contractor to measure the effectiveness and quality of Contractor's Care Management procedures. Such processes shall include:

(i) Identification of relevant measurement process or outcomes; and

(ii) Use of valid quantitative methods to measure outcomes against performance goals;

e) Include protocols for providing Care Management activities in each of the following settings. The Contractor shall exercise best efforts to provide Care Management in such settings:

(i) At adult and family shelters, for Enrollees who are homeless;

(ii) The Enrollee's home;

(iii) The Enrollee's place of employment or school;

(iv) At foster home, group homes and other residential placements especially for children in the care or custody of DCF and youth affiliated with DYS;

(v) At day health sites, such as for Adult Day Health;

(vi) 24-hour level of care facilities for Behavioral Health or substance use disorder treatment; or

(vii) Another setting of the Enrollee's choosing;

f) Include criteria and protocols for discharging Enrollees from Care Management;

g) Ensure that the Care Management activities each Enrollee is receiving are appropriately documented as further specified by EOHHS; and

h) Ensure regular contacts between Care Management staff, the Enrollee's PCP, and the Enrollee;

e. For Enrollees assigned to a BH- or LTSS CP, the Contractor shall coordinate with the Contractor's CPs for the provision of any Care Management activities to Enrollees, as described in **Section 2.5.E**, and Contractor shall ensure that Contractor's CPs are providing expertise and informing the development of Contractor's Care Management policies, procedures, and programs.

3. Care Management Program Compliance Review

To support evaluation of the Contractor's Care Management programs, the Contractor shall collaborate with EOHHS to develop specifications for a clinical data set and report**.** The Contractor shall analyze the data set and submit the results to EOHHS for review in a form, format, and frequency specified by EOHHS. The Contractor shall revise the clinical data set and report as directed by EOHHS; and

4. Any such Care Management approach shall be implemented in accord with any applicable EOHHS or other Commonwealth quality assurance and utilization review standards;

F. Behavioral Health Community Partners (BH CPs)

1. At all times after the Community Partners Operational Start Date, the Contractor shall maintain ACO/MCO – BH CP Agreements with BH CPs in each of the Contractor's Regions as follows and as further specified by EOHHS:

a. The Contractor shall not be required to maintain ACO/MCO-BH CP Agreements if so notified by EOHHS. Reasons for such notification may include the Contractor having a limited number of Enrollees over the age of 21, the Contractor having no shared

Enrollees with the BH CP, in EOHHS' sole determination, or other reasons specified by EOHHS; and

b. The Contractor shall not permit the Contractor's Material Subcontractor to enter into such ACO/MCO – BH CP Agreements on behalf of the Contractor.

2. The Contractor shall assign Enrollees identified by EOHHS, by the Contractor's internal identification criteria, or by referrals to BH CPs on a monthly basis as follows:

a. The Contractor shall develop, maintain, and provide to EOHHS upon request, internal identification criteria for Enrollee assignment to BH CPs.

b. The Contractor shall assign Enrollees to a BH CP;

1) With which the ACO/MCO has an ACO/MCO-CP Agreement;

2) That serves the geographic area in which the Enrollee lives, as specified by EOHHS; and

3) That has confirmed capacity to accept the assignment

c. The Contractor shall communicate such assignments to the BH CP in a form and format specified by EOHHS.

d. The Contractor shall submit enrollment and disenrollment requests to EOHHS, in a form and format specified by EOHHS.

3. With respect to BH CP-Referred Enrollees, the Contractor shall:

a. As further specified by EOHHS, develop, implement, and maintain policies and procedures for:

1) Accepting and evaluating such referrals; and

2) Determining the appropriateness of assigning BH CP-Referred Enrollees to a BH CP;

b. Accept and evaluate such referrals and determine whether it is appropriate to assign the BH CP-Referred Enrollee to a BH CP, consistent with the Contractor's policies and procedures;

c. Within thirty (30) calendar days of referral, assign BH CP-Referred Enrollees who the Contractor determines appropriate for assignment to a BH CP, subject to availability, including the BH CP's capacity;

d. As further specified by EOHHS, maintain documentation related to such referrals, including but not limited to information such as the name of the BH CP-Referred

Enrollee, name of the referrer, relation of the referrer to the BH CP-Referred Enrollee, date of referral, status of referral and the BH CP to which the BH CP-Referred Enrollee was assigned. The Contractor shall provide such documentation to EOHHS upon request;

4. For any BH CP Enrollee that is disenrolled from a BH CP, the Contractor shall ensure that such Enrollee receives Care Management, inclusive of behavioral health coordination and management, as appropriate;

5. The Contractor shall maintain appropriate BH CP enrollment volume as determined by and as further specified by EOHHS. The Contractor may be required to assign additional members to a BH CP at EOHHS's discretion.

6. The Contractor shall make best efforts to promptly begin coordinating with each BH CP with respect to the outreach, engagement, and care management of all BH CP-Assigned Enrollees assigned to that particular BH CP within seven (7) calendar days of the Contractor making such assignments. Such coordination shall include, but not be limited to:

    a. Providing the BH CP with the name and contact information for such BH CP-Assigned Enrollees;

    b. Providing necessary and appropriate information regarding the BH CP-Assigned Enrollee to the BH CP to assist in outreach and engagement;

    c. Communicating by phone or in person with the BH CP to coordinate plans to outreach to and engage the BH CP-Assigned Enrollee; and

    d. Other forms of communication or coordination pursuant to the Contractor's ACO/MCO – CP Agreement with each BH CP;

7. The Contractor shall accommodate requests from BH CP-Assigned or BH CP-Engaged Enrollees to switch CPs, as follows:

    a. As further specified by EOHHS, the Contractor shall develop and maintain policies and procedures for receiving, evaluating, and making determinations regarding such requests. Such policies and procedures shall account for BH CP-Assigned and BH CP-Engaged Enrollees' preferences;

    b. Within thirty (30) calendar days of receiving such request from BH CP-Assigned and BH CP-Engaged Enrollees, the Contractor shall make best efforts to accommodate such requests and reassign pursuant to the Contractor's policies and procedures, subject to availability, including the CP's capacity;

    c. The Contractor shall notify such Enrollees of the Contractor's decision to reassign or not to reassign, as further specified by EOHHS; and

d. As further specified by EOHHS, the Contractor shall maintain documentation related to such requests, including but not limited to information such as the name of the requesting BH CP-Assigned or BH CP-Engaged Enrollee, the CP to which the BH CP-Assigned or BH CP-Engaged Enrollee is assigned, the CP to which the BH CP-Assigned or BH CP-Engaged Enrollee is requesting to switch, if any, the date of request and the status of request. The Contractor shall provide such documentation to EOHHS upon request; and

e. As further specified by EOHHS, the Contractor shall transfer care-related information about a BH CP-Assigned or BH CP-Engaged Enrollee to the BH CP to which such Enrollee has been reassigned, including but not limited to the results of any Comprehensive Assessment and specified information from the Enrollee's Care Plan.

8. As further specified by EOHHS, the Contractor shall develop, implement, and maintain processes for:

a. Disengaging Enrollees from a BH CP, for reasons approved by EOHHS, including but not limited to when the Contractor, in consultation with the Enrollee's BH CP, determines that CP supports are no longer necessary, appropriate, or desired by the Enrollee; and

b. Determining when it is appropriate to transition responsibility for care coordination and care management from the BH CP to the Contractor for BH CP-Assigned or BH CP-Engaged Enrollees who have certain medical complexities, as further specified by EOHHS.

9. Contractor shall designate appropriate administrative staff to satisfy the requirements of this **Section 2.5.F** and **Appendix U**, including at a minimum:

a. One (1) key contact from each of the Contractor and the ACO Partner, if applicable, responsible for regular communication with the Contractor's BH CPs about matters such as but not limited to data exchange, care coordination and care management. The Contractor shall provide its BH CPs with information about each such key contact, including, but not limited to the contact's name, title, organizational affiliation, and contact information. The Contractor shall provide its BH CPs with timely notification if such key contact changes; and

b. A Care Team Point of Contact responsible for conducting all ongoing communication with the care team; ensuring the BH CP is notified of and included in the BH CP-Engaged Enrollee's Discharge Planning and follow-up communication during transitions of care; and updating the BH CP about Medically Necessary specialty care to which an Enrollee is referred or is receiving. The Contractor shall ensure that the Care Team Point of Contact has access to the Enrollee's medical record and possesses the appropriate qualifications to read clinical notations.

10. The Contractor and the BH CP shall enter into and adhere to a written ACO/MCO – BH CP Agreement as follows:

a. Each such agreement between the Contractor and a BH CP shall, at a minimum, comply with the requirements of **Appendix U**.

b. Such agreement between the Contractor and a BH CP may delegate additional responsibilities under this Contract from the Contractor to the BH CP provided such responsibilities:

1) Are agreed upon by the BH CP;

2) Comply with the requirements of this Contract;

3) Are in the best interests of Enrollees, and are intended to improve the coordination and Member-centeredness of care; and

4) Do not absolve the Contractor of any responsibility to EOHHS for the requirements of this Contract.

c. Such agreement between the Contractor and a BH CP may not obligate the BH CP to accept downside financial risk in Contract Year 1 or Contract Year 2.

11. As further specified by EOHHS, the Contractor shall report to EOHHS monthly, or at any other frequency specified by EOHHS, about the BH CPs, including but not limited to:

a. A list of BH CP-Identified Enrollees, including whether each Enrollee was assigned to a CP and the CP to which the Enrollee was assigned;

b. A list of BH CP-Referred Enrollees, including whether each Enrollee was assigned to a CP and the CP to which the Enrollee was assigned; and

c. A list of BH CP-Assigned Enrollees or BH CP-Engaged Enrollees who requested to switch their BH CP, including, for each such Enrollee, the reasons for the requested switch, and the outcome of the request.

G. Long Term Services and Supports Community Partners (LTSS CPs)

1. At all times after the Community Partners Operational Start Date, the Contractor shall maintain ACO/MCO – LTSS CP Agreements as follows and as further specified by EOHHS:

a. The Contractor shall maintain such Agreements with at least two LTSS CPs in each of the Service Areas that make up the Contractor's Regions, as further specified by EOHHS;

b. The Contractor shall not be required to maintain ACO/MCO-LTSS CP Agreements if so notified by EOHHS. Reasons for such notification may include the Contractor no shared Enrollees with the LTSS CP, in EOHHS' sole determination, or other reasons specified by EOHHS; and

c. The Contractor shall not permit the Contractor's Material Subcontractor to enter into such ACO/MCO LTSS CP Agreements on behalf of the Contractor;

2. The Contractor shall assign Enrollees identified by EOHHS, by the Contractor's internal identification criteria, or by referrals to LTSS CPs on a monthly basis as follows:

   a. The Contractor shall develop, maintain, and provide to EOHHS upon request, internal identification criteria for Enrollee assignment to LTSS CPs.

   b. The Contractor shall assign Enrollees to an LTSS CP

      1) With which the ACO/MCO has executed an ACO/MCO-CP Agreement;

      2) That serves the geographic area in which the member lives, as specified by EOHHS; and

      3) That has confirmed capacity to accept the assignment.

   c. The Contractor shall communicate those assignments to the LTSS CP in a form and format specified by EOHHS.

   d. The Contractor shall submit enrollment and disenrollment requests to EOHHS, in a form and format specified by EOHHS.

3. With respect to LTSS CP-Referred Enrollees, the Contractor shall:

   a. As further specified by EOHHS, develop, implement, and maintain policies and procedures for:

      1) Accepting and evaluating such referrals;

      2) Determining the appropriateness of assigning LTSS CP-Referred Enrollees to an LTSS CP;

   b. Accept and evaluate such referrals and determine whether it is appropriate to assign the LTSS CP-Referred Enrollee to an LTSS CP, consistent with the Contractor's policies and procedures;

   c. Within thirty (30) calendar days of referral, assign LTSS CP Referred Enrollees whom the Contractor determines appropriate for assignment to an LTSS CP, subject to availability, including the LTSS CP's capacity;

   d. As further specified by EOHHS, maintain documentation related to such referrals, including but not limited to information such as the name of the LTSS CP Referred Enrollee, name of the referrer, relation of the referrer to the LTSS CP Referred Enrollee, the date of referral, the status of the referral and the LTSS CP to which the

LTSS CP-Referred Enrollee was assigned. The Contractor shall provide such documentation to EOHHS upon request;

4. For any LTSS CP-Enrollee that is disenrolled from the CP Program, the Contractor shall ensure that such Enrollee receives Care Management, inclusive of behavioral health coordination and management, as appropriate;

5. The Contractor shall maintain appropriate LTSS enrollment volume as determined by and as further specified by EOHHS. The Contractor may be required to assign additional members to an LTSS CP at EOHHS's discretion.

6. The Contractor shall make best efforts to promptly begin coordinating with each LTSS CP with respect to the outreach, engagement, and LTSS care coordination of all LTSS CP-Assigned Enrollees assigned to that particular LTSS CP within seven (7) calendar days of the Contractor making such assignments. Such LTSS care coordination shall include, but not be limited to:

    a. Providing the LTSS CP with of the name and contact information for such LTSS CP-Assigned Enrollees;

    b. Providing necessary and appropriate information regarding the LTSS CP-Assigned Enrollee to the LTSS CP to assist in outreach and engagement;

    c. Communicating by phone or in person with the LTSS CP to coordinate plans to outreach to and engage the LTSS CP-Assigned Enrollee; and

    d. Other forms of communication or coordination pursuant to the Contractor's ACO/MCO – CP Agreement with each LTSS CP;

7. The Contractor shall accommodate requests from LTSS CP-Assigned or Engaged Enrollees to switch CPs, as follows:

    a. As further specified by EOHHS, the Contractor shall develop and maintain policies and procedures for receiving, evaluating and making determinations regarding such requests. Such policies and procedures shall account for LTSS CP-Assigned and LTSS CP-Engaged Enrollees' preferences;

    b. Within thirty (30) calendar days of such request from LTSS CP-Assigned and LTSS CP-Engaged Enrollees, the Contractor shall make best efforts to accommodate such requests and reassign pursuant to the Contractor's policies and procedures, subject to availability, including the CP's capacity;

    c. The Contractor shall notify such Enrollees of the Contractor's decision to reassign or not to reassign, as further specified by EOHHS; and

    d. As further specified by EOHHS, the Contractor shall maintain documentation related to such requests, including but not limited to information such as the name of the requesting LTSS CP-Assigned or LTSS CP-Engaged Enrollee, the CP to which the LTSS

CP-Assigned or LTSS CP Engaged-Enrollee is assigned, the CP to which the Enrollee is requesting to switch, if any, the date of request and the status of request. The Contractor shall provide such documentation to EOHHS upon request; and

e. As further specified by EOHHS, the Contractor shall transfer care-related information about a LTSS CP-Assigned or LTSS CP-Engaged Enrollee to the LTSS CP to which such Enrollee has been reassigned, including but not limited to the results of any Comprehensive Assessment and specified information from the Enrollee's Care Plan;

8. As further specified by EOHHS, the Contractor shall develop, implement, and maintain processes as further specified by EOHHS for disengaging Enrollees from an LTSS CP, including but not limited to when the Contractor, in consultation with the Enrollee's LTSS CP and the MCO-Administered ACO, as applicable, determines that CP supports are no longer necessary, appropriate, or desired by the Enrollee; and

9. The Contractor shall designate appropriate administrative staff to satisfy the requirements of this **Section 2.5.G and Appendix V**, including at a minimum one (1) key contact responsible for regular communication with the Contractor's LTSS CPs about matters such as but not limited to data exchange, care coordination and care management. The Contractor shall provide its LTSS CPs with information about such key contact, including, but not limited to the contact's name, title, organizational affiliation, and contact information. The Contractor shall provide its LTSS CPs with timely notification if such key contact changes;

10. The Contractor and the LTSS CP shall enter into and adhere to a written ACO/MCO – LTSS CP Agreement as follows:

    a. Each such agreement between the Contractor and a LTSS CP shall at a minimum comply with the requirements of **Appendix V**.

    b. Such agreement between the Contractor and a LTSS CP may delegate additional responsibilities under this Contract from the Contractor to the LTSS CP provided such responsibilities:

        1) Are agreed upon by the LTSS CP;

        2) Comply with the requirements of this Contract;

        3) Are in the best interests of Enrollees, and are intended to improve the coordination and member-centeredness of care; and

        4) Do not absolve the Contractor of any responsibility to EOHHS for the requirements of this Contract.

    c. Such agreement between the Contractor and an LTSS CP may not obligate the LTSS CP to accept downside financial risk in Contract Year 1 or Contract Year 2; and

11. As further specified by EOHHS, the Contractor shall report to EOHHS monthly, or at any other frequency specified by EOHHS, about the LTSS CPs, including but not limited to:

    a. A list of LTSS CP-Identified Enrollees, including whether each Enrollee was assigned to a CP and, the CP to which the Enrollee was assigned;

    b. A list of LTSS CP-Referred Enrollees, including whether each Enrollee was assigned to a CP and, the CP to which the Enrollee was assigned; and

    c. A list of LTSS CP-Assigned or LTSS CP-Engaged Enrollees who requested to switch their LTSS CP, including, for each such Enrollee, the reasons for the requested switch, and the outcome of the request.

H. Population and Community Needs Assessment and Risk Stratification

The Contractor shall implement a process for conducting a population and community needs assessment and risk stratification as described in this Section. The Contractor shall maintain policies and procedures documenting this process and submit such policies and procedures and data resulting from the assessment to EOHHS in a form and format specified by EOHHS

1. Population and Community Needs Assessment

   The Contractor's population and community needs assessment shall include the following components:

   a. Population Profiling:

      1) The population of Enrollees the Contractor serves and the communities in which they live, including at a minimum geographic location, settings, and socio-demographics (e.g. age, gender, race, ethnicity and housing status).

      2) The profile in a form and format as directed by EOHHS describing top inpatient, ED, and outpatient diagnoses and procedures, prevalent chronic conditions, and average cost incurred for inpatient, ED and outpatient services.

   b. Health Priorities: The health and functional needs of such population and communities; identifying and assessing health conditions and determinant factors with the most significant size and severity impact.

   c. Intervention and Engagement: Develop goals and plan interventions around priority populations addressing appropriate and timely care detailing:

      1) How the Contractor's planned activities and proposed investments will promote the health and wellbeing of Enrollees;

      2) How the Contractor plans to engage Enrollees and their communities; and

d. Determination of Resources: The community resources that currently exist for Enrollees, and how the Contractor is partnering or plans to partner with such resources for the purposes of this Contract;

2. Risk Stratification

The Contractor shall implement a risk stratification process that meets the requirements of this Section.

a. The Contractor shall predictably model, stratify and define the Enrollee population into risk categories, with at least one method to calculate a risk score for each Enrollee. The methodology shall:

1) At a minimum, utilizes claims and pharmacy data, laboratory data, referrals, data related to utilization management, and care needs assessment results to:

2) Assess the Enrollee's risk for high cost, high utilization, admission, re-admission, or other adverse health outcomes;

b. The Contractor shall document and detail the approach (e.g., use of specific risk assessment tool) and criteria employed to define and assign the risk categories of the population and provide such information to EOHHS upon request.

c. The Contractor shall utilize the stratification of Enrollees to inform its development and use of appropriate intervention approaches (such as Care Management) and maximize the impact of the services provided to Enrollees.

d. The Contractor shall stratify new Enrollees within 60 days of enrollment and re-stratify the all Enrollees at a minimum bi-annually.

Section 2.6 Covered Services

A. Covered Services and Other Benefits

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

1. Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary MCO Covered Services listed in **Appendix C**, in accordance with the requirements of this Contract, and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under MassHealth fee-for-service;

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

a. Prevent, diagnose, and treat disease, conditions, or disorders that result in health impairments;

b. Achieve age-appropriate growth and development; and

c. Attain, maintain, or regain functional capacity;

3. Not arbitrarily deny or reduce the amount, duration, or scope of a required MCO Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee;

4. Not deny authorization for an MCO Covered Service demonstrated to be Medically Necessary by a health care professional who has the clinical expertise in treating the Enrollee's medical condition or in performing the procedure or providing treatment, whether or not there is a Non-MCO Covered Service that might also meet the Enrollee's medical needs. Failure to provide Medically Necessary MCO Covered Services may result in intermediate sanctions pursuant to **Section 5.3.K** of the Contract;

5. The Contractor may place appropriate limits on an MCO Covered Service on the basis of Medical Necessity, or for the purpose of utilization control, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

   a. Developed with input from practicing physicians throughout the Contractor's Regions;

   b. Developed in accordance with standards adopted by national accreditation organizations;

   c. Developed in accordance with the definition of Medical Necessity in **Section 1** of this Contract and therefore no more restrictive than MassHealth Medical Necessity guidelines, QTLs and NQTLs;

   d. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

   e. Evidence-based, if practicable; and

   f. Applied in a manner that considers the individual health care needs of the Enrollee, including but not limited to the ongoing need for services of Enrollees with ongoing or chronic conditions;

6. Submit changes to its Medical Necessity guidelines, program specifications and services components for all MCO Covered Services to EOHHS no less than 60 days prior to any change, or another timeframe specified by EOHHS;

7. Coordinate the provision of all Non-MCO Covered Services listed in **Appendix C** in accordance with the requirements of this Contract. The Contractor shall inform Enrollees and Providers of:

   a. The availability of such services; and

   b. How to access such services through EOHHS's prior authorization process, where applicable;

8. Not be responsible for providing to Enrollees or coordinating any Excluded Services as described in **Appendix C**;

9. Offer to MassHealth Enrollees any additional Non-Medical Programs and Services available to a majority of the Contractor's commercial population 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. The Contractor is not permitted to submit the cost of Non-Medical Programs and Services in the report specified by EOHHS and found in **Appendix A** as an administrative, medical or other expense;

10. Offer and provide to all Enrollees any and all Non-Medical Programs and Services specific to Enrollees for which the Contractor has received EOHHS approval;

11. For items or services provided under this Contract, the Contractor shall not cover such services outside the U.S and its territories and shall not provide any payments for such items or services to any entity or financial institution located outside the U.S.; and

12. The Contractor shall ensure that criminal justice involved Enrollees have access to medically necessary MCO Covered Services, including Behavioral Health Services, and Care Management and care coordination as appropriate, as otherwise provided in this Contract;

13. The Contractor shall:

    a. Not impose on an Enrollee an annual dollar limit or an aggregate lifetime dollar limit on Behavioral Health Services; and

    b. Not impose on an Enrollee any quantitative treatment limitation, as defined in 42 C.F.R. 438.900, on Behavioral Health Services.

14. The Contractor shall not avoid costs of providing MCO Covered Services by referring Enrollees to publicly supported health care resources.

B. Prescription Drug Management Program

1. The Contractor shall maintain a comprehensive prescription drug management program as follows.

    a. Management and Support

        The Contractor shall:

        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) Participate in EOHHS Pharmacy Directors' Workgroup meetings and other standing or ad hoc meetings, task forces, or workgroups as necessary to support this Contract; and

3) Establish and maintain a call center to answer questions and provide support to pharmacy Providers and to prescribers.

b. Drug Coverage

The Contractor shall:

1) Cover all prescription and over-the-counter drugs as described in **Appendix C,** consistent with the MassHealth Drug List;

2) Operate and maintain a state-of-the-art National Council for Prescription Drug Programs (NCPDP)-compliant, on-line pharmacy claims processing system. Such system must allow for:

a) Financial, eligibility, and clinical editing of claims;

b) Messaging to pharmacies;

c) Pharmacy "lock-in" procedures consistent with MassHealth's controlled substance management program described at 130 CMR 406.442 using criteria equivalent to MassHealth criteria for enrollment listed on the MassHealth Drug List;

d) Downtime and recovery processes;

e) Electronic prescribing; and

f) Claims from 340B entities as directed by EOHHS including but not limited to capturing 340B indicators and being able to process NCPDP standard transactions B1 (claim billing), B2 (claim reversal), and B3 (claim rebill).

g) Having a separate BIN, PCN, and group number combination for MassHealth claims to differentiate them from commercial claims. The Contractor shall notify EOHHS if this BIN, PCN, and group number combination changes as set forth in Appendix A.

c. Clinical Management

The Contractor shall:

1) Establish and maintain a drug list which includes coverage of all prescription, over-the-counter drugs, and Non-Drug Pharmacy Products as described in

Appendix C, consistent with the MassHealth Drug List, and appropriate processes in support of the drug list including:

a) Convening a Pharmacy and Therapeutics Committee;

b) Conducting Drug Utilization Review processes consistent with the requirements of 42 USC 1396r-8, and 42 CFR 45 including but not limited to:

(i) Annually, and at other frequencies if specified by EOHHS, reporting to EOHHS on Drug Utilization Review (DUR) activities in a form and format specified by EOHHS and in accordance with **Appendix A**.

(ii) Participating in EOHHS' MassHealth DUR advisory board.

(iii) Upon EOHHS request, in a form and format specified by EOHHS and as set forth in **Appendix A**, submit to EOHHS the Contractor's prior authorization criteria for therapeutic categories of drugs specified by EOHHS and any related analysis.

c) At EOHHS' direction, synchronizing the management of particular therapeutic areas with MassHealth's management of those therapeutic areas, including at a minimum, controlled substances and behavioral health medications in children. As determined appropriate by EOHHS, the Contractor shall also synchronize related programs and policies such as the Controlled Substance Management Program (CSMP) or lock-in criteria and operations.

d) Routinely reporting to EOHHS, in a form and format and frequency specified by EOHHS, prior authorization criteria, utilization and other metrics in therapeutic areas.

e) Promoting the use of generic drugs and as identified by EOHHS, Preferred Drugs, and Non-Drug Pharmacy Products;

f) Providing electronic access to the drug list by posting the list on the Contractor's website in a machine-readable file and format. Such list shall include which medications are covered (generic and name brand) and, if applicable, what tier a medication is on; and

g) Conducting educational interventions or other outreach to prescribers to support drug list management objectives;

2) Include a prior authorization or other review process to determine Medical Necessity for prescription and over-the-counter drugs. For any process that

requires the Contractor's approval prior to dispensing drugs, the Contractor shall make a decision to approve, modify or deny the pharmacy's authorization request by telephone or other electronic means within 24 hours of receipt of the request. The Contractor shall provide for pharmacy providers to dispense at least a 72-hour emergency supply of drugs, using override codes and without the need to contact the Contractor's pharmacy benefit manager for approval, pending resolution of a prior authorization request and shall provide payment to pharmacy providers for such dispensed emergency supplies. The Contractor shall have policies and procedures that allow for a greater than a 72-hour emergency supply as determined appropriate in the pharmacist's professional judgement. Furthermore, upon three-day's notice from EOHHS and for such periods of time as EOHHS directs, the Contractor shall provide for pharmacy providers to dispense up to a 30-day emergency supply of drugs, using override codes and without the need to contact the Contractor's pharmacy benefit manager for approval, pending resolution of a prior authorization request and shall provide payment to pharmacy providers for such dispensed emergency supplies.

3) Establish and maintain pharmacy "lock-in" procedures consistent with MassHealth's controlled substance management program described at 130 CMR 406.442 using the criteria for enrollment equivalent to MassHealth criteria listed on the MassHealth Drug List. Such procedures shall include processes that identify potential fraud or abuse by Enrollees, and review such Enrollees to see whether enrollment in "lock-in" is appropriate.

4) Work with EOHHS and other MassHealth-contracted MCOs and Accountable Care Partnership Plans to develop and implement an improved communication and tracking system for EOHHS and the MassHealth-contracted MCOs and Accountable Care Partnership Plans to monitor Members in MassHealth's controlled substance management program who change health plans. The Contractor shall provide EOHHS with information on Enrollees in a controlled substance management program, as specified by EOHHS and in a form and format and at a frequency specified by EOHHS and in accordance with **Appendix A**; and

5) As further specified by EOHHS, participate in planning efforts with EOHHS about a prescriber "lock-in" program and, as determined by and as further specified by EOHHS, establish and maintain such program.

6) As further specified by EOHHS, monitor antipsychotic prescribing for children by implementing Prior Authorization requirements consistent with the Pediatric Behavioral Health Medication Initiative (PBHMI) regarding the prescribing of psychoactive medications for Enrollees under age 18. Requirements must be submitted to EOHHS prior to implementation. The Contractor shall:

a) Implement the age restrictions that are part of such Prior Authorization requirements;

b) Implement the polypharmacy restrictions that are part of such Prior Authorization requirements for approval by EOHHS; and

c) Report on PBMHI in a format and at a frequency specified by EOHHS and **Appendix A**.

7) As further directed by EOHHS, with respect to the HCV Drugs, develop and implement Prior Authorization requirements and other utilization management requirements consistent with MassHealth Prior Authorization criteria and utilization management requirements;

8) If directed by EOHHS, the Contractor shall develop and implement prior authorization requirements and other utilization management requirements consistent with MassHealth prior authorization criteria and utilization management requirements, and provide such requirements to EOHHS in a form, format, and frequency specified by EOHHS and in accordance with **Appendix A**.

9) 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:

a) Safety edits, including but not limited to, as further directed by EOHHS:

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

(ii) Implementing a safety edit for concurrent chronic use of opioids and benzodiazepines, and review automated processes;

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

(i) Having a method to monitor and report on concurrent chronic use of opioids and antipsychotics and

(ii) Monitoring antipsychotic medications in children by continuing to implement the Pediatric Behavioral Health Medication Initiative (PBHMI), a program to monitor antipsychotic medications in children, as described in **Section 2.6.B.c.6**; and

c) 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; and

d) Any required claims review automated processes.

d. Network

The Contractor shall:

1) Contract with a pharmacy Network that provides access to pharmacies throughout the Contractor's Regions as described in **Section 2.9.C**;

2) Not reimburse pharmacies associated with Federally Qualified Health Centers (FQHCs) and enrolled in the federal 340B Drug Pricing Program, as determined by EOHHS, for drugs purchased through the federal 340B Drug Pricing Program;

3) Unless otherwise directed by EOHHS, establish and pay provider rates for pharmacies associated with entities enrolled in the federal 340B Drug Pricing Program at or above the provider rates the Contractor pays to pharmacies who are not associated with entities enrolled in the federal 340B Drug Pricing Program;

4) The Contractor may propose to maintain a specialty pharmacy program for its Enrollees. If contracted with a Specialty Pharmacy for certain drugs, the Contractor shall ensure those contracts allow flexibility to implement policies required by EOHHS, including, but not limited to the following:

a) The Contractor's specialty pharmacy program shall allow an Enrollee to designate a provider or other representative who may be able to verify need, confirm, or accept deliveries on their behalf.

b) The Contractor's specialty pharmacy program shall have the ability to provide a drug at the retail level when an Enrollee needs access to the medication in less than 24 hours.

c) If the Contractor covers Vivitrol™ as a specialty pharmacy benefit, the Contractor shall allow Enrollees to do a first-fill at any pharmacy and not just as specialty pharmacies. First fill is defined as a new start or a

re-initiation of therapy. EOHHS may, at its discretion, expand this requirement to other drugs as it determines appropriate.

5) The Contractor shall, with respect to drug classes specified by EOHHS, including but not limited to hepatitis C virus (HCV) Drugs, provide coverage in a manner that maximizes EOHHS' ability to collect drug rebates, including but not limited to excluding such drug classes from reimbursement through the Contractor's 340B program, as further specified by EOHHS;

6) Consistent with Section 2.15.M, the Contractor shall pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) at least the amount MassHealth would pay for prescribed drugs on a fee-for-service basis. Specifically, the Contractor shall pay FQHCs and RHCs for prescribed drugs not obtained through the 340B Drug Pricing Program at least the amount derived using one of the following methodologies:

   a) the National Drug Average Acquisition Cost (NADAC) of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or

   b) the wholesale acquisition cost (WAC) of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or

   c) the usual and customary charge.

7) As further specified by EOHHS, for Non-HCV High Cost Drugs that are also on the MassHealth Acute Hospital Carve-Out Drugs List, pay for such drugs consistent with the methodology EOHHS uses in its fee-for-service program.

e. Reporting and Analysis

The Contractor shall:

1) Include data collection, analysis, and reporting functions related to individual and aggregate physician prescribing and Enrollee utilization, to identify Enrollees who would benefit from Disease Management or Case Management interventions;

2) Respond to requests by EOHHS for custom reports, particularly in support of cooperative data analysis efforts; and

3) Report to EOHHS annually, in accordance with **Appendix A**, a geographic access report of the Contractor's pharmacy network.

4) Report monthly to EOHHS, in a form and format specified by EOHHS and in accordance with **Appendix A**, on the Contractor's utilization management activities related to HCV drugs. Such report shall include, at a minimum, Enrollees treated, claim count, adherence rate, cure rate, genotype, and fibrosis levels;

2. Mail Order Pharmacy Program

The Contractor may propose to develop a voluntary mail order pharmacy program for the Contractor's Enrollees in accordance with EOHHS requirements. Pharmacy co-payments must be in the same amounts as the pharmacy co-payments established by EOHHS for Members not enrolled in an Accountable Care Partnership Plan or MassHealth-contracted MCO. See 130 CMR 450.130. The Contractor must continue to assure adequate access to pharmacy services for all Enrollees, regardless of whether the Enrollee chooses to receive mail order pharmacy services.

a. As a part of its proposal, the Contractor must submit to EOHHS a description of the mail order pharmacy program. At a minimum, such description shall include:

1) A proposed time frame for implementing the mail order pharmacy program;

2) The drugs included and excluded in such a mail order pharmacy program, including specialty and non-specialty mail-order drugs;

3) How the Contractor plans to address the following issues:

a) Pharmaceutical diversion and early refills;

b) Emergency refills; and

c) Access to pharmacist counseling on the proper use of medication, including drug interaction safety;

4) A draft of notices to Enrollees about the mail order pharmacy program;

5) A description of training on the mail order pharmacy program to all employees, including customer service representatives, the pharmacy benefit manager, and Providers; and

6) A brief description of the methods by which the Contractor will assure compliance with all applicable requirements of this Contract and federal and state law.

b. The mail order pharmacy program is subject to EOHHS's review and prior approval. EOHHS, in its sole discretion, may accept all, part, or none of a Contractor's proposed mail order pharmacy program.

c. If the Contractor establishes a mail order pharmacy program that includes specialty drugs, the Contractor's program must comply with the requirements in Section 2.6.B.1.d.4

d. If the Contractor establishes a mail order pharmacy program, the Contractor shall submit the mail order pharmacy report in the form and format described in **Appendix A**, and any other ad hoc reports as directed by EOHHS.

3. Pharmacy Co-payments

The Contractor shall:

a. Implement co-payments for pharmacy services as provided in **Section 5.1.K.2**;

b. On a nightly basis, transmit to MMIS, pharmacy co-payment information for Enrollees who have either met the annual pharmacy co-payment cap, or who have been disenrolled from the Contractor's Plan;

c. Include provisions in all Provider Contracts with pharmacies that prohibit the pharmacy from denying prescription drugs to Enrollees based on an Enrollee's inability to pay his or her co-payment; and

d. Develop written standard operating procedures for addressing pharmacies that repeatedly deny prescription drugs to Enrollees based on the Enrollee's reported inability to pay the pharmacy co-payment. Such standard operating procedures shall include:

1) A process for outreaching to the Enrollee and ensuring availability of the needed prescription drugs in a timely manner;

2) Reminding the pharmacy that denying prescription drugs to Enrollees based on an Enrollee's inability to pay his or her co-payment is a violation of its Provider Contract with the Contractor;

3) Providing EOHHS with a list of any pharmacies that demonstrate a pattern of inappropriately denying prescription drugs to Enrollees, and the steps taken to resolve the situation; and

4) Taking disciplinary action against the noncompliant pharmacy, if necessary.

4. Obligations of the MCOs to Support Rebate Collection

The Contractor shall take all steps necessary to participate in, and support EOHHS' participation in, federal and supplemental drug rebate programs and to participate in and support any rebate program for Non-Drug Pharmacy Products (including, but not limited to, blood glucose test strips) as directed by EOHHS and as follows:

a. The Contractor shall ensure EOHHS obtains all drug and Non-Drug Pharmacy Product utilization data in accordance with the requirements set forth by EOHHS. The Contractor shall participate and cooperate with EOHHS in activities meant to assist EOHHS with identifying and appropriately including eligible drug claims in the federal drug rebate program and eligible claims for Non-Drug Pharmacy Product rebates.

b. The Contractor shall perform all system and program activities determined necessary to:

1) Properly identify drugs purchased through the Federal 340B Drug Pricing Program; and

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:

a) 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),

b) Metric Quantity, and

c) Unit of Measure.

c. The Contractor shall take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize drug and Non-Drug Pharmacy Product rebate collection. Such steps shall include:

1) Aligning the Contractor's drug and Non-Drug Pharmacy Product (or equivalent) list(s) to include individual drugs or therapeutic classes and Non-Drug Pharmacy Products as designated by EOHHS in the MassHealth ACPP/MCO Unified Pharmacy Product List or as otherwise specified by EOHHS, including but not limited to:

a) Designating drugs and Non-Drug Pharmacy Products as Preferred Drugs and Non-Drug Pharmacy Products consistent with the MassHealth ACPP/MCO Unified Pharmacy Product List or as otherwise specified by EOHHS, and changing such designation as directed by EOHHS; and

b) Developing and implementing Prior Authorization requirements and other Utilization Management requirements, such as step therapy, on preferred and non-preferred drugs within the designated therapeutic classes identified in the MassHealth ACPP/MCO Unified Pharmacy Product List and drugs identified in the MassHealth Acute Hospital Carve-Out Drugs List or as otherwise specified by EOHHS;

c) Developing and implementing Prior Authorization requirements and other Utilization Management requirements on preferred and non-preferred Non-Drug Pharmacy Products identified in the MassHealth ACPP/MCO Unified Pharmacy Product List or as otherwise specified by EOHHS;

2) Excluding certain drugs or drug classes, set forth in the MassHealth ACPP/MCO Unified Pharmacy Product List or as otherwise specified by EOHHS, from reimbursement through the Contractor's 340B program;

3) Terminating, and not entering into, rebate agreements with its Pharmacy Benefit Managers (PBMs) or with manufacturers for drugs or drug classes as specified by EOHHS;

4) Terminating, and not entering into, rebate agreements with its Pharmacy Benefit Managers (PBMs) or with manufacturers for Non-Drug Pharmacy Products set forth in the MassHealth ACPP/MCO Unified Pharmacy Product List as specified by EOHHS;

5) Signing up to receive notifications from EOHHS of changes to the MassHealth Drug List, which would include any updates to the MassHealth ACPP/MCO Unified Pharmacy Product List;

6) Providing a link to or posting a copy of the MassHealth ACPP/MCO Unified Pharmacy Product List.

7) Taking any other steps that are necessary for EOHHS to maximize rebate collection.

d. The Contractor shall ensure that the Drug and Non-Drug Pharmacy Product Rebate contractual requirements are transferred completely and without interruption to the published MassHealth Drug Rebate and Non-Drug Pharmacy Product rebate file upload schedule whenever there is a change in the Drug Rebate operations and/or "technical support staff."

e. The Contractor shall make all appropriate efforts to meet utilization targets for the Contract Year as set and directed by EOHHS for Preferred Drugs and Non-Drug Pharmacy Products set forth in the MassHealth ACCP/MCO Unified Pharmacy Product List, including but not limited to targets for particular classes.

1) EOHHS shall provide the Contractor with such utilization targets at least annually. Such utilization targets may change during the Contract Year.

2) EOHHS shall calculate, for utilization targets other than those that are set as "N/A,":

a) at least quarterly, whether the Contractor is on track to meet such utilization targets for the Contract Year and provide the Contractor with a report showing the results.

b) for the Contract Year, whether the Contractor met such utilization targets for the Contract Year and provide the Contractor with a report showing the results.

3) For such calculations in **Section 2.6.B.4.e.2** above, EOHHS shall use quarterly Encounter Data to determine the ratio of Preferred Drugs and Non-Drug Pharmacy Products paid by the Contractor compared to all drugs and Non-

Drug Pharmacy Products paid by the Contractor, as appropriate based on the Contract Year's utilization targets. Such calculation may be done at the class level and at the thirty-day supply level. (e.g. Encounter Data showing a ninety-day supply will be considered three thirty-day supplies).

4) If the Contractor does not meet the lower bound of such utilization target for the Contract Year, EOHHS shall apply a Capitation Payment deduction in accordance with **Section 6.3.K**.

5) For utilization targets except those where the higher bound of the utilization target is 100%, if the Contractor exceeds the higher bound of such utilization target for the Contract Year, EOHHS shall pay the Contractor in accordance with **Section 4.3.G**.

6) EOHHS shall not apply Capitation Payment deductions or make any payments, as described in **Section 2.6.B.4.e.4-5** above, with respect to utilization targets identified as "N/A". EOHHS shall also not make any payment described in **Section 2.6.B.4.e.5** where the higher bound of the utilization target is 100%.

7) The calculation of a Capitation Payment deduction and payment described in **Section 2.6.B.4.e.4-5** above shall exclude drugs purchased through the federal 340B Drug Pricing Program.

5. 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.

6. Pharmacy Benefits Manager Pricing Report

As further specified by EOHHS, the Contractor shall, in accordance with Appendix A and in a form and format specified by EOHHS, submit on both a quarterly and ad hoc basis a Pharmacy Benefits Manager Pricing Report. The Pharmacy Benefits Manager Pricing Report shall include, but may not be limited to, the following information as further specified by EOHHS:

a. At the Claim level:

1) Payments to each dispensing pharmacy by the Pharmacy Benefits Manager (PBM); and

2) Payments to the PBM by the Contractor

b. At the National Drug Code level:

1) Volume of drugs

2) Rebate dollar amounts received by the PBM from any manufacturer; and

3) Rebate dollar amounts paid to the Contractor by the PBM

c. At the aggregate level:

1) Any administrative payments made to the Contractor by any PBM or to any PBM by the Contractor; and

2) Any administrative payments made to a dispensing pharmacy contracted with the Contractor by any PBM contracted with the Contractor or to any PBM contracted with the Contractor from any dispensing pharmacy contracted with the Contractor.

C. Authorization of Services

In accordance with 42 CFR 438.210, the Contractor shall authorize services as follows:

1. For the processing of requests for initial and continuing authorizations of MCO Covered Services, the Contractor shall:

a. Have in place and follow written policies and procedures;

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

c. Consult with the requesting Provider when appropriate.

2. The Contractor shall ensure that a Plan physician and a behavioral health specialist is available 24 hours a day for timely authorization of Medically Necessary services and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary.

3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must 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. 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.

4. The Contractor must notify the requesting Provider, either orally or in writing, and give the Enrollee 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 that is less than requested. The notice must meet the requirements of 42 CFR 438.404 and **Section 2.12.B.2**, and must:

a. Be produced in a manner, format, and language that may be easily understood;

b. Be made available in Prevalent Languages, upon request; and

c. Include information, in the most commonly used languages about how to request translation services and Alternative Formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency.

5. The Contractor must make authorization decisions in the following timeframes:

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

1) The Enrollee or the Provider requests an extension, or

2) The Contractor can justify (to EOHHS upon request) that:

a) The extension is in the Enrollee's interest; and

b) There is a need for additional information where:

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

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

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

1) The Enrollee or the Provider requests an extension; or

2) The Contractor can justify (to EOHHS upon request) that:

a) The extension is in the Enrollee's interest; and

b) There is a need for additional information where:

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

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

c. In accordance with 42 CFR part 438 and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

6. The Contractor and its Behavioral Health subcontractor, if any, must provide Medical Necessity criteria for prior authorization upon the request of an Enrollee, a MassHealth Provider, or the MassHealth agency. This requirement may be fulfilled by publishing the criteria on the Contractor's website.

7. For all covered outpatient drug authorization decisions, the Contractor shall provide notice as described in Section 1927(d)(5)(A) of the Social Security Act; and

8. For any Enrollees that disenroll from the Contractor to enroll in the MassHealth PCC Plan, a MassHealth-contracted MCO, or another Accountable Care Partnership Plan, the Contractor shall develop, implement, and maintain policies and procedures for sharing information on service authorizations with MassHealth or such MCO or such Accountable Care Partnership Plan;

D. Utilization Management

The Contractor shall maintain a Utilization Management plan and procedures consistent with the following:

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. All of the team members shall:

a. Be in compliance with all federal, state, and local professional licensing requirements;

b. Include representatives from appropriate specialty areas. Such specialty areas shall include, at a minimum, cardiology, epidemiology, OB/GYN, pediatrics, addictionology, child and adolescent psychiatry, and adult psychiatry;

c. Have at least two or more years' experience in managed care or peer review activities, or both;

d. 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

e. Not have any legal sanctions relating to his or her professional practice including, but not limited to, malpractice actions resulting in entry of judgment against him or her, unless otherwise agreed to by EOHHS.

2. In addition to the requirements set forth in paragraph 1 above, the Medical Director's designee for behavioral health Utilization Management shall also:

   a. Be board certified or board eligible in psychiatry; and

   b. Be available 24 hours per day, seven days a week for consultation and decision-making with the Contractor's clinical staff and Providers.

3. The Contractor shall have in place policies and procedures that at a minimum:

   a. Routinely assess the effectiveness and the efficiency of the Utilization Management program;

   b. Evaluate the appropriate use of medical technologies, including medical procedures, Behavioral Health treatments, drugs and devices;

   c. Target areas of suspected inappropriate service utilization;

   d. Detect over- and under-utilization;

   e. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

   f. Compare Enrollee and Provider utilization with norms for comparable individuals;

   g. Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services, and out-of-Network services, as well as Behavioral Health Inpatient and Outpatient Services, Diversionary Services, and ESPs;

   h. 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 and other Providers as appropriate;

   i. 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;

   j. Refer suspected cases of Provider or Enrollee Fraud or Abuse to EOHHS within 10 days;

   k. Address processes through which the Contractor monitors issues identified by the Contractor, EOHHS, Enrollees, and Providers, including the tracking of issues and resolutions over time; and

   l. Are communicated, accessible, and understandable to internal and external individuals, and entities, as appropriate.

4. The Contractor's Utilization Management activities shall include:

a. Referrals and coordination of MCO and Non-MCO Covered Services;

b. Authorization of MCO Covered Services, including modification or denial of requests for such services;

c. Assisting Providers to effectively provide inpatient Discharge Planning;

d. Behavioral health treatment and Discharge Planning;

e. Monitoring and assuring the appropriate utilization of specialty services, including Behavioral Health Services;

f. Notwithstanding any other provision contained herein, the Contractor may 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™). Contractor must 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 and not just at specialty pharmacies. First fill is defined as a new start or a re-initiation of therapy.

g. Providing training and supervision to the Contractor's Utilization Management clinical staff and Providers on:

    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) Utilization Management policies, practices and data reported to the Contractor to ensure that it is standardized across all Providers within the Contractor's Provider Network; and

    3) The consistent application and implementation of the Contractor's Clinical Criteria and guidelines including the Behavioral Health Clinical Criteria approved by EOHHS;

h. Monitoring and assessing Behavioral Health Services and outcomes measurement, specifically using the CANS Tool for Enrollees under 21, and using any standardized clinical outcomes measurement tools that are submitted by Providers and reviewed and approved by the Contractor for Enrollees age 21 or older. The Contractor's behavioral health 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

i. Care Management programs.

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:

    a. That the clinician coordinating and authorizing adult mental health services shall be a clinician with experience and training in adult mental health services;

    b. That the clinician coordinating and authorizing child and adolescent mental health services shall be a clinician with experience and training in child and adolescent mental health services and in the use of the CANS Tool;

    c. That the clinician coordinating and authorizing adult substance use disorders shall be a clinician with experience and training in adult substance use disorders;

    d. That the clinician coordinating and authorizing child and adolescent substance use disorders shall be a clinician with experience and training in child and adolescent substance use disorders; and

    e. That the clinician coordinating and authorizing services for Enrollees with Co-Occurring Disorders shall have experience and training in Co-Occurring Disorders.

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.

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, and were authorized and billed in accordance with the Contractor's requirements.

8. The Contractor shall have policies and procedures for conducting monthly reviews of a random sample of no fewer than 500 Enrollees to ensure that such Enrollees received the services for which Providers billed with respect to such Enrollees; and

9. The Contractor shall monitor and ensure that all Utilization Management activities provided by a Material Subcontractor comply with all provisions of this Contract.

10. The Contractor shall conduct the utilization activities set forth below, as further specified by EOHHS.

    a. The Contractor shall develop and implement a process for monitoring and addressing high Emergency Department (ED) utilization. The Contractor shall have a process that consists of the following activities:

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

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

a) Non-Emergent

b) Emergent/Primary Care Treatable

c) Emergent- ED Care Needed – Preventable/Avoidable

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

b. Beginning in Year 2 of the Contract, the Contractor shall calculate ED utilization and submit the results to EOHHS, using ED visit severity algorithm measure specifications provided by EOHHS.

c. The Contractor shall conduct, for acute inpatient level of care, pre-admission screening for all elective medical and surgical admissions and, for acute rehabilitation level of care, shall conduct pre-admission screening and concurrent review, as follows:

1) Pre-admission screening shall be conducted in accordance with 130 CMR 450.207 and 130 CMR 450.208 and shall review for medical necessity and appropriate setting on all medical and surgical elective admissions to all acute hospitals for all Enrollees, including for out-of-state services, except for the elective admissions of:

a) Enrollees for whom EOHHS is not the primary payer of the acute hospital admission, including but not limited to Enrollees covered by an MCO, an Accountable Care Partnership Plan, commercial insurance, or Medicare;

b) Enrollees who are recipients of the Emergency Aid to the Elderly, Disabled, and Children Program;

c) Enrollees whose hospitalization is court ordered; and

d) Delivery-related admissions of Enrollees.

2) Concurrent reviews shall be the assessment of the medical necessity for a continued hospital stay at acute rehabilitation level of care and for all services

provided during such continued stay. Such review may be performed at any time subsequent to the Enrollee's admission.

d. At a frequency and in a form and format specified by EOHHS, the Contractor shall calculate and report to EOHHS the measures specified below, in accordance with any specifications provided by EOHHS. The Contractor shall also report on any programs the Contractor has in place addressing adverse trends identified through this analysis.

1) Inpatient Admissions

a) Surgical Admissions: total admissions, admissions/1000, and Per Member Per Month costs

b) Medical Admissions: total admissions, admissions/1000, and Per Member Per Month costs

2) Primary Care Visits: total visits, visits/1000, and Per Member Per Month costs

3) Home Health Services

a) Skilled Nursing Visits: total visits, visits/1000, and Per Member Per Month costs

b) Home Health Aide Visits: total visits, visits/1000, and Per Member Per Month costs

c) Physical, Occupational and Speech Therapy Visits (as part of Home Health): total visits, visits/1000, and Per Member Per Month costs

4) Radiology Outpatient Services

a) Computerized Axial Tomography Visits (CPT codes 70450 through 70470, 70480 through 70498, 71250 through 71275, 72125 through 72133, 72191 through 72194, 73200 through 73206, 73700 through 73206, 73700 through 73706, 74150 through 74178, 74261 through 74263, 75571 through 75574, 77011 through 77014, 0066T, 0067T, 76380, 77078, G0288): total visits, visits/1000, and Per Member Per Month costs

b) Magnetic Resonance Imaging Visits (CPT codes 70540 through 70559, 71550 through 71555, 72141 through 72159, 72195 through 72197, 73218 through 73225, 73718 through 73725, 74181 through 74185, 75557 through 75565, C8903 through C8908, 72198, 76390, 77021, 77084): total visits, visits/1000, and Per Member Per Month costs

c) Positron Emission Tomography Visits (CPT codes 78608 through 78816, 78491, 78492, 78459): total visits, visits/1000, and Per Member Per Month costs

d) Nuclear Cardiology (MUGA scans, perfusion imaging) Visits (CPT codes 78414, 78428, 78451 through 78754, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496, 78499): total visits, visits/1000, and Per Member Per Month costs

e) Magnetic Resonance Angiography Visits (CPT codes 74185, 73225, 71555, 70544 – 70546, 73725, 70547-70549, 72198, 72159): total visits, visits/1000, and Per Member Per Month costs

5) Outpatient Therapy Services

a) Physical Therapy Visits: total visits, visits/1000, and Per Member Per Month costs

b) Occupational Therapy Visits: total visits, visits/1000, and Per Member Per Month costs

c) Speech Therapy Visits: total visits, visits/1000, and Per Member Per Month costs

6) Laboratory and Pathology: total claims, claims/1000, and Per Member Per Month costs

7) Behavioral Health

a) Behavioral Health Inpatient Admissions: admissions, admissions/1000, and Per Member Per Month costs

b) Behavioral health penetration rate per 1000

c) Average length of stay for a Behavioral Health inpatient stay

e. The Contractor shall identify high utilizers and indicate to EOHHS goals and processes to reduce utilization by these Enrollees. The Contractor shall:

1) Define high utilizers as the top 3% in overall expenditures for the Calendar Year;

2) As further specified by EOHHS, report to EOHHS, for the Calendar Year:

a) The number of Enrollees identified,

b) The services those Enrollees received, and

c) The total costs for those Enrollees.

3) Identify new high utilizers at a minimum twice annually;.

4) Examine utilization patterns of Enrollees and identify and monitor those at risk of being high utilizers.

E. Behavioral Health Services: Authorization Policies and Procedures

The Contractor shall:

1. Review and update annually, at a minimum, the Behavioral Health Clinical Criteria definitions and program specifications for each MCO Covered Service. The Contractor shall submit any modifications to these documents 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 treatment in Massachusetts;

2. Review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health Services authorization policies and procedures;

3. Develop and maintain Behavioral Health Inpatient Services and 24-Hour Diversionary Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:

   a. If prior authorization is required for any Behavioral Health Inpatient Services admission or 24-Hour Diversionary Service, assure the availability of such prior authorization 24 hours a day, seven days a week;

   b. A plan and a system in place to direct Enrollees to the least intensive but clinically appropriate service;

   c. For all Behavioral Health emergency inpatient admissions:

      1) A system to provide an initial authorization, where applicable, and communicate the initial authorized length of stay to the Enrollee, facility, and attending physician. Such initial authorization and communication must be provided verbally within 30 minutes for emergency admissions, and within 2 hours for non-emergency inpatient admissions and in writing within 24 hours of all admissions;

      2) Policies and procedures to ensure compliance by the Contractor and any of the Contractor's Material Subcontractors with **Section 2.6.E.3.c.1**;

   d. Processes to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available;

   e. 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 treatment goals;

f. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans and 24-Hour Diversionary Services treatment plans;

g. 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;

h. Retrospective reviews of the medical records of selected Behavioral Health Inpatient Services admissions and 24-Hour Diversionary Services cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care;

i. Prior authorization shall not be required for Inpatient Substance Use Disorder Services (Level 4), Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7), Clinical Support Services for Substance Use Disorders (Level 3.5), and Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) as defined in **Appendix C**;

j. Providers providing Clinical Support Services for Substance Use Disorders (Level 3.5) shall provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee; and

k. If utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level 3.5), such activities may be performed no earlier than day 7 of the provision of such services.

l. A process for monitoring 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**.

4. Develop and maintain non-24-Hour Diversionary Services authorization policies and procedures. Such policies and procedures shall be submitted to EOHHS for review and approval;

5. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

a. Policies and procedures to automatically authorize at least 12 Behavioral Health Outpatient Services;

b. Policies and procedures for the authorization of all Behavioral Health Outpatient Services beyond the initial 12 Outpatient Services;

c. Policies and procedures to authorize Behavioral Health Outpatient Services based upon behavioral health Clinical Criteria; and

d. 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.

6. Implement defined Utilization Management strategies for CBHI Services that are standardized across all MassHealth managed care entities.

7. Not impose on an Enrollee an annual dollar limit or an aggregate lifetime dollar limit on BH Covered Services;

8. Not impose on an Enrollee any quantitative treatment limitation, as defined in 42 C.F.R 438.900, on BH Covered Services.

F. Services for Specific Populations

The Contractor shall provide or arrange health care services to MassHealth Standard and CommonHealth Enrollees under the age of 21, in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements at 42 CFR 441.56(b) and (c), and 130 CMR 450.140 et seq., as those regulations may be amended, ensuring that its Providers do the same.

In addition, the Contractor shall:

1. At the direction of EOHHS, actively participate in initiatives, processes and activities of EOHHS agencies with which Enrollees have an affiliation. Such agencies include, but are not limited to:

   a. The Department of Mental Health (DMH);

   b. The Department of Children and Families (DCF);

   c. The Department of Youth Services (DYS);

   d. The Department of Public Health and DPH's Bureau of Substance Abuse Services (DPH/BSAS);

   e. The Department of Developmental Disabilities (DDS);

   f. The Massachusetts Rehabilitation Commission (MRC);

   g. The Massachusetts Commission for the Blind (MCB); and

   h. The Massachusetts Commission on the Deaf and Hard of Hearing.

2. When an Enrollee is involved with one or more EOHHS agency, including but not limited those listed in paragraph 1 above, notify such agencies of an Enrollee's admission to an inpatient facility within one business day of the facility's admission notification with respect to such Enrollee;

3. Ensure that services are provided to children in the care or custody of DCF, and youth affiliated with DYS (either detained or committed), as follows:

    a. Ensure that Providers make best efforts to provide the 7-day medical screenings and 30-day comprehensive medical evaluations, which shall include the EPSDT screens appropriate for the child's age, for their Enrollees who are taken into DCF custody;

    b. Ensure that Primary Care, including EPSDT screenings are delivered according to the EPSDT Periodicity Schedule;

    c. Make best efforts to provide foster parents with current medical information about the Enrollees placed in their care in a timely manner;

    d. Ensure that Providers make best efforts to communicate with the DCF caseworker(s) assigned to Enrollees in DCF care or custody and inform them of services provided through the Contractor's Plan;

    e. Ensure that Providers make best efforts to communicate with the DYS caseworker(s) assigned to Enrollees in DYS and inform them of services provided through the Contractor's Plan;

    f. Designate a DCF liaison to work with designated EOHHS staff and the DCF Regional Nurses throughout the Contractor's Regions. Such liaison shall:

        1) Have at least two years of Care Management experience, at least one of which should include working with children in state custody;

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

            a) Establishing and maintaining contact with the DCF Regional Directors and Regional Nurses throughout the Contractor's Regions;

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

            c) As requested by DCF, provide advice and assistance to Regional Directors or Regional Nurses on individual cases regarding MCO Covered Services and coordinating Non-MCO Covered Services;

            d) Assisting DCF caseworkers and, if requested by DCF, foster parent(s), in obtaining appointments in compliance with **paragraph 2.a** above;

            e) If requested by DCF, work with providers of 24-hour services to coordinate Discharge Planning;

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

g) Perform any functions to assist the Contractor in complying with the requirements of this **Section 2.6.F.3.f**.

g. Designate a DYS liaison to work with designated EOHHS staff and the DYS. Such liaison shall:

1) Have at least two years of Care Management experience, at least one of which should include working with children in state custody;

2) Establish and maintain contact with designated DYS staff and be available to assist EOHHS and DYS in the resolution of any problems or issues that may arise with a DYS-affiliated Enrollee;

3) If requested by DYS, work with providers of 24-hour Inpatient or Diversionary Services to coordinate Discharge Planning;

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

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

6) As requested by DYS, provide advice and assistance to DYS Regional Directors on individual cases regarding MCO Covered Services and coordinating Non-MCO Covered Services;

7) Assist DYS caseworkers in obtaining appointments in compliance with **Section 2.6.D.3.g**;

8) Actively participate in the planning and management of services for DYS youth (committed or detained); and

9) Perform any functions to assist the Contractor in complying with the requirements of this **Section 2.6.F.3.g**.

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

a. Ensure that Primary Care is delivered to all Enrollees;

b. Ensure that Primary Care is delivered to children and adolescents, including EPSDT screenings according to the EPSDT Periodicity Schedule; and

c. Ensure that Providers make best efforts to communicate with the DMH caseworker(s) assigned to Enrollees and inform them of the services provided through the Contractor's Plan;

5. Designate a DMH liaison to work with designated EOHHS agencies and DMH. Such liaison shall:

a. Have at least two years of Care Management experience, at least one of which must be working with individuals in need of significant Behavioral Health Services;

b. Actively participate in the planning and management of services for individuals who are clients of DMH. This shall include, but not be limited to:

1) Establishing and maintaining contact with 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) Upon request of DMH, participating in regional informational and educational meetings with DMH staff and, as directed by DMH, family members and Peer Supports;

3) As requested by DMH, providing advice and assistance to Regional Directors or case managers on individual cases regarding MCO Covered Services and coordinating Non-MCO covered services;

4) If requested by DMH, working with Providers of 24-hour Inpatient or Diversionary Services to coordinate Discharge Planning;

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

6) Performing any functions to assist the Contractor in complying with the requirements of **Section 2.6.F.4 and 5** above;

7) Assisting DMH caseworkers with obtaining appointments in compliance with **Section 2.9.B**;

6. Designate a liaison to work with designated EOHHS staff and the EOHHS Assistant Secretary for Disabilities and Community Services (ODSC). Such liaison shall:

a. Have at least two years of Care Management experience, at least one of which must be working with adults who:

1) Have developmental disabilities;

2) Have severe physical disabilities;

3) Are deaf or hard of hearing; or

4) Are blind or visually impaired;

b. Establish and maintain contact with designated ODSC staff and be available to assist EOHHS and ODSC in the resolution of any problems or issues that may arise with an Enrollee affiliated with an ODSC agency;

c. Upon request of ODSC, participate in regional informational and educational meetings with EOHHS staff or staff of any of the OSCDC agencies, and, as directed by EOHHS, individuals, caregivers, or other family member(s);

d. As requested by ODSC, provide advice and assistance to Regional Directors or Regional Nurses on individual cases regarding MCO Covered services and coordinating Non-MCO Covered services; and

e. As requested by EOHHS, actively participate in any joint meetings or workgroups with EOHHS agencies and other Accountable Care Partnership Plans and MassHealth-contracted MCOs;

7. Provide or arrange preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, in accordance with EPSDT and PPHSD guidelines for individuals under age 21, other guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice;

8. 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;

9. Comply with the Early Intervention (EI) requirements set forth in 130 CMR 440.00, as those regulations may be amended, to establish and maintain a comprehensive, community based program for MassHealth Standard and CommonHealth Enrollees between the ages of birth and three years, whose developmental patterns are atypical or, are at serious risk to become atypical, through the influence of certain biological or environmental factors;

10. Provide or arrange family planning services as follows:

a. 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;

b. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the Contractor's Provider Network;

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

1) All methods of contraception, including sterilization, vasectomy, and emergency contraception;

2) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and

3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination;

d. Maintain sufficient family planning providers to ensure timely access to family planning services.

11. Provide systems and mechanisms designed to make medical history and treatment information available to the greatest extent possible at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as people who are homeless; and

12. Comply with the Commonwealth's screening process for placement of individuals aged 21 or younger in pediatric nursing facilities in accordance with 130 CMR 456.408(A)(1).

G. Emergency and Post-Stabilization Care Service Coverage

1. The Contractor shall cover and pay for Emergency Services in accordance with 42 CFR 438.114 and Mass. Gen. Laws ch. 118E, section 17A.

2. The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor. The Contractor shall pay a non-contracted provider of Emergency and Post-Stabilization Services an amount equal to or, if the Contractor can negotiate a lower payment, less than the amount allowed under the state's Fee-For Service rates, less any payments for indirect costs of medical education and direct costs of graduate medical education. The Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.

3. The Contractor shall not deny payment for treatment for an Emergency Medical Condition.

4. 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.

5. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

6. The Contractor shall require providers to notify the Enrollee's Primary Care Provider of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

7. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

8. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor if:

    a. Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and

    b. Is a covered benefit under the Contract.

9. The Contractor shall cover and pay for Post-Stabilization Care Services in accordance with 42 CFR 438.114(e), 42 CFR 422.113(c), and Mass. Gen. Laws ch. 118E, section 17A.

H. Nursing Facility Stay

If it appears that an Enrollee's stay in a Nursing Facility may exceed 100 days of service within a calendar year, the Contractor shall:

1. Outreach to the Provider to determine whether the Enrollee's stay is anticipated to exceed 100 days within the calendar year; and

2. Prior to the Enrollee receiving 100 days of service at the facility, submit the MassHealth SC-1 and screening forms to EOHHS in a form and format specified by EOHHS and work with the Enrollee and Enrollee's Authorized Representative to ensure the Enrollee has appropriate MassHealth coverage for post-100 day stay.

I. Service Codes

When directed by EOHHS, the Contractor shall cover and use the service codes provided by, and as updated by, EOHHS representing the MCO Covered Services set forth in Appendix C. The Contractor shall also use such codes provided by EOHHS when representing any Non-MCO Covered Services or excluded services set forth in **Appendix C**;

J. AND Status Data

As directed by EOHHS, the Contractor shall collect and report data to EOHHS regarding Enrollees on Administratively Necessary Days (AND) status in a 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.

K. In Lieu of Services or Settings

1. In accordance with 42 CFR 438.3(e)(2) and 438.6(e), the Contractor may cover the Inpatient Behavioral Health Services set forth in **Appendix C** delivered in Institutions for Mental Disease (IMD), as defined in Section 1905(i) of the Social Security Act, as identified by EOHHS, as an in lieu of service or setting for Enrollees between the ages of 21-64, provided that:

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

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

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

2. For any Enrollee between the ages of 21-64 who received the Inpatient Behavioral Health Services set forth in **Appendix C** in an IMD for more than 15 days in any calendar month, the Contractor shall:

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

1) The Enrollee's rating category;

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

3) Any other information requested by EOHHS; and

b. As further specified and directed by EOHHS, reconcile the capitation payment received by the Contractor pursuant to **Section 4.2** for the calendar month in which the Enrollee received the Inpatient Behavioral Health Services set forth in **Appendix C** in an IMD for more than 15 days.

3. IMD settings are set forth in **Appendix G,** which may be updated from time to time.

L. Compliance with Federal Regulations for PASRR Evaluations

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. 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, the Contractor shall ensure that the Provider does not attempt to bill the Enrollee for such services.

Section 2.7 Provider Network, Provider Contracts, and Related Responsibilities

A. Provider Network

1. General requirements for the Provider Network

a. 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 adequate access to MCO Covered Services. 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;

b. 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. When directed by EOHHS:,

1) Such Providers must be enrolled with EOHHS as specified by EOHHS; and.

2) The Contractor may execute Provider Contracts for up to 120 days pending the outcome of EOHHS' enrollment process, but must terminate a Provider Network immediately upon notification from EOHHS that the Network Provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider. The Contractor shall notify affected Enrollees of the termination.

c. The Provider Network shall include a sufficient number of Providers with appropriate expertise in treating Enrollees with BH or LTSS needs to address the care needs of such Enrollees;

d. The Contractor shall make best efforts to ensure that SDO-certified businesses and organizations are represented in the Provider Network. The Contractor will submit annually the appropriate **Appendix A** certification checklist on its efforts to contract with SDO-certified entities;

e. As requested by EOHHS, the Contractor shall, in a form and format specified by EOHHS and in accordance with **Appendix Q**, report to EOHHS data specifications related to its Network Providers, including but not limited to whether each Network Provider is enrolled as a MassHealth provider, and any other information requested by EOHHS about its Network Providers including but not limited to each Provider's MassHealth billing ID, provider ID/service location (PID/SL), NPI, tax ID (or TIN), and known affiliations to other providers;

f. In establishing and maintaining the Provider Network, the Contractor must consider the following:

1) The anticipated MassHealth enrollment;

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

3) The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the MCO Covered Services;

4) The number of Network Providers who are not accepting new patients; and

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;

g. The Contractor shall implement written policies and procedures for the selection and retention of Providers in accordance with 42 CFR 438.214, including but not limited to ensuring such policies and procedures for Providers do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;

h. The Contractor shall ensure that the Provider Network provides Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for MCO Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs;

i. The Contractor's Provider Network shall include freestanding birth centers licensed by the Commonwealth of Massachusetts Department of Public Health;

j. 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;

k. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, Enrollees with Special Health Care Needs, including individuals with disabilities, or other special populations served by the Contractor, by, at a minimum, having the capacity to, when necessary, communicate with Enrollees in languages other than English, communicate with individuals who are deaf, hard-of-hearing, or deaf blind, and making materials and information available in Alternative Formats as specified in this Contract;

l. The Contractor shall ensure that its Network Providers and Material Subcontractors meet all current and future state and federal eligibility criteria, standard and ad hoc reporting requirements, and any other applicable rules and/or regulations related to this Contract; and

m. 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.

n. As further specified by EOHHS, the Contractor shall

1) Include in its Provider Network the following state agency providers:

a) The providers set forth in **Appendix G, Exhibit 3** identified as providing inpatient behavioral health services as described in **Appendix C, Exhibit 3,** including inpatient mental health services; and

b) The providers set forth in **Appendix G, Exhibit 3** identified as providing Acute Treatment Services (ATS) and Clinical Support Services (CSS) as described in **Appendix C, Exhibit 3.**

2) Not require the state agency providers described in Section 2.7.A.1.n.1 to indemnify the Contractor, to hold a license, or to maintain liability insurance; and

3) If required by EOHHS, include in its Provider Network or pay as out-of-network providers, other state agency providers as set forth in **Appendix G**.

2. Out-of-Network Access

The Contractor shall maintain and utilize protocols to address situations when the Provider Network is unable to provide an Enrollee with appropriate access to MCO 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 2.9.C**. The Contractor's protocols must ensure, at a minimum, the following:

a. If the Contractor is unable to provide a particular MCO Covered Service or medical diagnostic equipment through a its Provider Network, it will be adequately covered in a timely way out-of-network;

b. When accessing an out-of-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;

c. That out-of-network providers must 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;

d. That the particular service will be provided by the most qualified and clinically appropriate provider available;

e. 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;

f. That the provider will be informed of his or her obligations under state or federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Enrollee in his or her primary language;

g. 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;

h. That consideration is given for an out-of-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; and

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

3. Additional Provider Network Requirements for Behavioral Health Services

The Contractor shall:

a. Ensure that its Behavioral Health Provider Network includes an adequate number of Providers with experience and expertise in various specialty populations. 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) diagnostic needs as described in the most recent publication, the Contractor shall ensure that its Behavioral Health Provider Network has expertise in the following specialty populations and conditions:

1) Co-Occurring Disorders;

2) Serious and persistent mental Illness;

3) Children and adolescents, including children and adolescents with Serious Emotional Disturbance and Autism Spectrum Disorder;

4) Physical disabilities and chronic illness;

5) Deaf and hard of hearing and blind or visually impaired;

6) HIV/AIDS;

7) Homelessness;

8) Child Welfare and juvenile justice;

9) Fire-setting behaviors;

10) Sex-offending behaviors;

11) Post-adoption issues; and

12) Substance use disorders;

b. 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;

c. 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;

d. 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;

e. For Behavioral Health Inpatient and 24-hour Diversionary Services:

1) Ensure that all Behavioral Health Inpatient and 24-Hour Diversionary Services Provider Contracts require the Behavioral Health Inpatient and 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) Promote continuity of care for Enrollees who are readmitted to Behavioral Health Inpatient and 24-Hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility;

3) Require Behavioral Health Inpatient and 24-Hour Diversionary Services Providers to coordinate treatment and Discharge Planning with the state agencies (e.g., DCF, DMH, DYS, DDS) with which the Enrollee has an affiliation;

4) Ensure that all Behavioral Health Inpatient and 24-Hour Diversionary Services Providers have:

a) Human rights and restraint and seclusion protocols that are consistent with the DMH requirements in **Appendix G** and regulations and include training of the Provider's staff and education for Enrollees regarding human rights;

b) 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, in accordance with **Appendix G** and with applicable DMH regulations and requirements;

5) Require that Behavioral Health Inpatient and 24-hour Diversionary Services Providers coordinate with contracted ESPs throughout the Contractor's Regions, including procedures to credential and grant admitting privileges to ESP Provider psychiatrists; and

6) Convene regular meetings and conduct ad hoc communication on clinical and administrative issues with ESPs to enhance the continuity of care for Enrollees

7) The Contractor shall incorporate DMH's Infection Control Competencies/Standards, as set forth in Attachments A and B to DMH Licensing Bulletin 20-05R for Tier 1 and Tier 2 DMH-licensed facilities, respectively, 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.C.3. 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.C.3**, including, as appropriate, recouping the rate increases set forth in **Section 2.20.B.3**.

f. As directed by EOHHS, contract with the network of Community Services Agencies (CSAs) in the Contractor's Service Area(s) to provide Intensive Care Coordination and Family Support and Training Services to MassHealth Standard and CommonHealth Enrollees. For each of these services, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 352, unless otherwise directed by EOHHS, and shall, as directed by EOHHS, use the procedure codes to provide payment for such services. As directed by EOHHS, the Contractor shall pay certain CSAs identified by EOHHS a daily case rate specified by EOHHS.

g. As directed by EOHHS, contract with a network of Providers to provide the following services, when Medically Necessary, to the specific groups of Enrollees indicated below:

1) Family Support and Training Services, to MassHealth Standard and CommonHealth Enrollees;

2) In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services, to MassHealth Standard and CommonHealth Enrollees; and

3) In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support), to all Enrollees under age 21;

h. For each of the services listed in **paragraph g** above, establish provider rates at or above the rate floor set by EOHHS in 101 CMR 352, unless otherwise directed by

EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

i. As directed by EOHHS and by the Effective Date of the Contract, contract with selected ESP providers to provide Youth Mobile Crisis Intervention when Medically Necessary to all MassHealth Enrollees under the age of 21. For this service, the Contractor shall establish provider rates at or above the rate floor specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

j. [Reserved].

k. Behavioral Health Emergency Screening, Emergency Services Programs (ESPs), and Youth Mobile Crisis Intervention.

1) ESP Contracts

The Contractor shall:

a) Execute and maintain contracts with the ESPs identified in **Appendix G, Exhibit 1** of this Contract, as updated by EOHHS from time to time, that are located throughout the Contractor's Regions to provide Behavioral Health ESP services as set forth in **Appendix C**, as applicable, to this Contract;

b) Submit ESP Performance Specifications;

c) Arrange for out-of-network services, when necessary, with any ESP Provider not in the Contractor's Network;

d) Not require ESP Providers to obtain prior authorization to provide ESP Encounters or Youth Mobile Crisis Intervention to Enrollees;

e) Provide payment for services provided by such ESP Providers to Enrollees;

f) Ensure that contracted ESP Providers utilize, as is necessary, the statewide Massachusetts Behavioral Health Access website; and

g) As directed by EOHHS, take all steps and perform all activities necessary to execute contracts with the ESP Provider network, including, without limitation, participation in meetings and workgroups, the development and implementation of new policies, and any other tasks as directed by EOHHS.

2) Enrollee Access to Behavioral Health ESP Providers

The Contractor shall:

a) Ensure that Enrollees have unrestricted access to Behavioral Health ESP Providers, as described in **Appendix C**, as applicable, in response to a behavioral health crisis on a 24-hour basis, seven days a week, including the availability of ESP Provider clinicians who have special training or experience in providing Behavioral Health Services to:

(i) Children and adolescents. Clinicians providing Behavioral Health ESP services to children and adolescents must be child-trained clinicians who meet Youth Mobile Crisis Intervention competency standards as set forth in program service specifications approved by EOHHS;

(ii) Individuals with substance use disorders;

(iii) Individuals with developmental disabilities including mental retardation or autism spectrum disorders;

(iv) Elderly persons; and

b) Permit Enrollees access to Behavioral Health Services provided by ESP Providers through direct self-referral, the Contractor's toll-free telephone line, or referral by family members or guardians, individual practitioners, PCPs, or community agencies or hospital emergency departments; and

c) Require that the response time for face-to-face evaluations by ESP Providers does not exceed one hour from notification by telephone from the referring party or from the time of presentation by the Enrollee.

d) Have policies and procedures to monitor Enrollee access to ESPs and, as requested by EOHHS and in accordance with **Appendix A**, report, in a form and format as specified by EOHHS, about such access.

3) ESP Policies and Procedures

The Contractor shall:

a) Have policies and procedures to monitor the ESP Provider network's performance with respect to established diversion and inpatient admission rates;

b) Have policies and procedures to monitor the ESP Provider network's performance with respect to diverting encounters with Enrollees from

hospital emergency departments to the ESP Providers' community-based locations or other community settings;

c) Have policies and procedures regarding the circumstances under which ESP Providers shall contact the Contractor for assistance in securing an inpatient or 24-Hour Diversionary Service placement. Such policies and procedures shall include that if an ESP Provider 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 out-of-network Providers to identify such a facility;

d) Have policies and procedures to ensure collaboration between ESP Youth Mobile Crisis Intervention teams, Community Service Agencies (CSAs), and other youth serving Providers;

e) Have a plan in place to direct Enrollees to the least intensive but clinically appropriate service;

f) Have a process to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available;

g) Utilize standardized documents such as risk management/safety plans as identified by EOHHS;

h) Convene meetings to address clinical and administrative issues with ESP Providers and to enhance the coordination of care for Enrollees;

i) Attend statewide ESP meetings convened by the EOHHS' Behavioral Health contractor;

j) Develop additional policies and procedures with respect to ESPs, as directed by EOHHS, and submit such policies and procedures to EOHHS for review and approval; and

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

   (i) ESP Providers 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

(ii) If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), and ESP Provider determines that such admission is Medically Necessary, the ESP 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.

l. Medication for Addiction Treatment (MAT) Services

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

2) The Contractor shall include in its Provider Network, qualified providers to deliver MAT 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:

a) All Opioid Treatment Program (OTP) providers licensed by the Bureau of Substance Addiction Services (BSAS); and

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

3) The Contractor shall ensure that all such Providers of MAT Services coordinate and integrate care with Enrollees' PCPs and other providers in response to Enrollees' needs; and

4) As further directed by EOHHS, the Contractor shall ensure Enrollees may receive MAT Services through qualified PCPs in the Provider Network; and

5) The Contractor shall not require an authorization or referral for MAT Services, unless otherwise directed by EOHHS.

4. Community Partners

a. The Contractor shall have agreements with Behavioral Health Community Partners (BH CPs) and Long Term Services and Supports Community Partners (LTSS CPs) as described in **Sections 2.5.F and 2.5.G**;

b. The Contractor shall support relationships between Community Partners and MCO-Administered ACOs as further directed by EOHHS.

c. As requested by EOHHS, the Contractor shall report, in a form and format as specified by EOHHS, about Enrollees with relationships with CPs in accordance with **Appendix A**.

5. As further directed by EOHHS, the Contractor shall establish and implement policies and procedures to increase the Contractor's capabilities to share information among providers

involved in Enrollees' care, including increasing connection rates of Network Providers to the Mass HIway, adopting and integrating interoperable certified Electronic Health Records (EHR) technologies (such as those certified by the Office of the National Coordinator (ONC), enhancing interoperability, and increasing the use of real time notification of events in care (such as but not limited to admission of an Enrollee to an emergency room or other care delivery setting) ; and

6. As requested by EOHHS, the Contractor shall submit a complete database in a form and format and according to data standards specified by EOHHS, of all Network Providers, including but not limited to Network PCPs, and including unique National Provider Identifiers (NPIs) for each such Network Provider. Such database shall be submitted on a monthly basis via a system interface as further directed by EOHHS.

B. Provider Contracts

1. General

The Contractor shall:

a. Maintain all Provider Contracts and other agreements and subcontracts relating to this Contract, including agreements with out of 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 out of network providers include the following provision: "Providers shall not seek or accept payment from any Enrollee for any MCO Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any MCO Covered Service rendered to an Enrollee. Instead, Providers shall look solely to the (Contractor's name) for payment with respect to MCO 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.

b. Actively monitor the quality of care provided to Enrollees under any Provider Contracts and any other subcontracts;

c. 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 the prior review and approval of EOHHS;

d. Require a National Provider Identifier on all claims and provider applications;

e. 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), except for the Contractor's Provider Contracts with Network PCPs, which shall include the provisions specified in **Section 2.7.C.1**; and

f. With respect to all Provider Contracts, comply with 42 CFR 438.214, including complying with any additional requirements as specified by EOHHS;

2. Additional Standards for Provider Contracts and other agreements with providers

The Contractor shall maintain contracts in writing (Provider Contracts) with all Network Providers as follows:

a. All such Provider Contracts and agreements, including single case agreements, with out-of-network providers must:

1) Be in writing;

2) Contain, at a minimum, the provisions described in this Section; and

3) Comply with all applicable provisions of this Contract;

b. The Contractor shall not acquire established networks without executing a Provider Contract with each Provider that complies with all of the provisions of this **Section 2.7.B.**, and any other applicable provisions of this Contract, and contacting each Provider to ensure that the Provider understands the requirements of this Contract and agrees to fulfill all terms of the Provider Contract In Provider organizations where the organization represents the Provider in business decisions (e.g. a medical group or health center), a Provider Contract with the Provider organization shall be sufficient to satisfy this requirement. EOHHS reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to Network Providers, the existence of a contract between the Contractor and each individual Provider in the Provider Network;

c. The Contractor shall ensure that all Provider Contracts prohibit Providers, including but not limited to PCPs, from:

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) Billing patients for charges for MCO or Non-MCO Covered Services other than pharmacy co-payments;

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;

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

d. The Contractor shall ensure that all Provider Contracts specify that:

1) No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition as described in **Section 1**;

2) As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 CFR 447.26(d) and as may be specified by the Contractor. The Provider shall comply with such reporting requirements to the extent the Provider directly furnishes services;

3) The Contractor shall not refuse to contract with or pay an otherwise eligible health care provider for the provision of MCO Covered Services solely because such Provider has in good faith:

a) Communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such Provider's patients; or

b) Communicated with one or more of his prospective, current or former patients with respect to the method by which such Provider is compensated by the Contractor for services provided to the patient;

4) No contract between the Contractor and a Provider may contain any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay or limit specific, Medically Necessary Services, as described in **Section 2.7.D** and further specified by EOHHS;

5) A Provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions;

6) Neither the Contractor nor the Provider has the right to terminate the contract without cause and shall require the Provider to provide at least 60 days' notice to the Contractor and assist with transitioning Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee;

7) The Contractor shall provide a written statement to a Provider of the reason or reasons for termination with cause;

8) The Contractor shall notify Providers in writing of modifications in payments, modifications in covered services or modifications in the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Contractor and the Provider or unless such change is mandated by the state or federal government without 30 days prior notice; and

9) Providers shall participate in Contractor's continuity of care policies and procedures as described in **Section 2.2.C**;

e. The Contractor shall not enter into a new contract, revise the risk arrangements in an existing contract, or revise the fee schedule in an existing contract with a Provider that is a physician or physician group which imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:

1) Stop-loss protection;

2) Minimum patient population size for the physician or physician group; and

3) Identification of the health care services for which the physician or physician group is at risk.

f. Contracts between the Contractor and Providers shall require Providers to comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services;

g. Contracts between the Contractor and Providers shall require Providers to participate, as further directed by EOHHS, in any EOHHS efforts or initiatives as described in **Section 2.3.B.5**; and

h. Nothing in this Section shall be construed to restrict or limit the rights of the Contractor to include as Providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers;

C. Additional Responsibilities for Certain Providers

1. Primary Care Providers (PCPs)

a. The Contractor shall enter into a contract with each PCP that:

1) Requires the PCP to:

a) Share clinical data on Enrollees with the Contractor as required to support the Quality Measure reporting requirements described in **Appendix B** subject to all applicable laws and regulations;

b) Observe and comply with all applicable member rights and protections in this Contract;

c) Provide care to Enrollees in accordance with the requirements described in **Section 2.5**, and otherwise assist the Contractor with meeting the requirements of this Contract, including documenting information in an Enrollee's medical record;

d) Perform, at a minimum, the following activities:

(i) Supervising, coordinating and providing care to each assigned Enrollee;

(ii) For children and adolescents under 21, providing services according to the EPSDT Periodicity Schedule, including the administration of behavioral health screenings in accordance with **Section 2.7.C.2**;

(iii) 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 an out-of-network provider, to confirm with the Contractor that the Contractor will cover the Enrollee seeing that out-of-network provider and also inform the Enrollee to speak with the Contractor before seeing that out-of-network provider;

(iv) Ensuring that Enrollees who are identified as requiring Behavioral Health Services are offered referrals for Behavioral Health Services, when clinically appropriate;

(v) Maintaining continuity of care for each assigned Enrollee; and

(vi) 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;

e) Perform Enrollee screenings as follows:

(i) Screen all MassHealth Standard and CommonHealth Enrollees under age 21 according to the EPSDT Periodicity Schedule and 130 CMR 450.140-149;

(ii) Screen all MassHealth Family Assistance Enrollees under age 21 according to the EPSDT Periodicity Schedule and 130 CMR 450.150;

(iii) Provide or refer all MassHealth Standard and CommonHealth Enrollees under age 21 for medically necessary treatment services in accordance with EPSDT requirements;

(iv) Provide or refer all MassHealth Family Assistance Enrollees under age 21 for medically necessary treatment services included in their benefit package;

(v) For Enrollees under 21, require PCPs to use the standardized Behavioral Health screening tools described in the EPSDT Periodicity Schedule when conducting Behavioral Health screenings according to the EPSDT Periodicity Schedule and 130 CMR 450.140-150. The Contractor shall submit a quarterly report to EOHHS, in the form and format found in **Appendix A**, by the last day of the quarter, or the next business day if the last day is not a business day, following the end of each quarter, documenting the number of behavioral health screenings provided to Enrollees during the quarter; and

(vi) The Contractor shall establish discrete rates for behavioral health screenings and shall use the same procedure codes as used by EOHHS to provide payment for such screenings.

2) Has a term of a minimum of one year from the Operational Start Date; and

3) May only be terminated for cause;

b. The Contractor shall ensure that PCPs utilize a Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for Enrollees;

c. 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; and

d. The Contractor shall not allow any individual PCP to have a panel that includes more than fifteen hundred (1500) Enrollees at any point in time, unless the Contractor requests and receives prior written approval from EOHHS to temporarily waive this maximum. Such approval shall be granted at the sole discretion of EOHHS;

2. Behavioral Health Providers

The Contractor shall enter into and oversee Provider Contracts with Network Providers who provide Behavioral Health Services as follows:

a. The Contractor shall ensure that such Provider Contracts shall require that clinicians, including psychiatrists, psychiatric residents, psychiatric nurse mental-health clinical specialists, psychologists, Licensed Independent Clinical Social Workers (LICSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), and unlicensed Master's level clinicians working under the supervision of a licensed clinician, who provide Behavioral Health Services to Enrollees under the age of 21 in certain levels of care, including Diagnostic Evaluation for Outpatient Therapy (individual Counseling, Group Counseling, and Couples/Family Counseling), In-Home Therapy, Inpatient Psychiatric Services, and Community Based Acute Treatment Services:

1) Participate in CANS training sponsored by EOHHS;

2) Become certified in the use of the CANS Tool and recertified every two years;

3) Use the CANS Tool whenever they deliver a Behavioral Health Clinical Assessment for an Enrollee under the age of 21, including the initial Behavioral Health Clinical Assessment and, at a minimum, every 90 days thereafter during ongoing treatment;

4) Use the CANS Tool as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services; and

5) Subject to consent by the Enrollee, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT system the information gathered using the CANS Tool and the determination whether or

not the assessed Enrollee is suffering from a Serious Emotional Disturbance (SED).

b. The Contractor shall ensure that such Provider Contracts with Community Service Agencies require that intensive care coordinators of all levels:

1) Become certified in the use of the CANS Tool and re-certified every two years;

2) Use the CANS Tool during the comprehensive home-based assessment that is part of the initial phase of Intensive Care Coordination (ICC), at least every 90 days thereafter during ongoing care coordination, and as part of Discharge Planning from ICC services; and

3) Subject to consent by the Enrollee, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT System the information gathered using the CANS Tool and a determination as to whether or not the Enrollee meets the definition of an SED;

c. The Contractor shall ensure that such Provider Contracts require all Behavioral Health Providers who have clinicians who are required to provide Behavioral Health Clinical Assessments and perform the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services using the CANS Tool in accordance with **Section 2.7.C.2.a**. above, have Virtual Gateway accounts and a high speed internet or satellite internet connection to access the CANS IT System, provided that the Contractor may have policies and procedures approved by EOHHS to grant temporary waivers for these requirements on a case by case basis;

d. The Contractor shall establish policies and procedures that:

1) Require Behavioral Health Providers who are required to provide Behavioral Health Clinical Assessments and perform the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services using the CANS Tool in accordance with **Section 2.7.C.2.a**. to seek consent from the Enrollee, parent, guardian, custodian, or other authorized individual, as applicable, before entering CANS assessments into the CANS IT System using the form of consent approved by EOHHS;

2) Require Behavioral Health Network Providers who obtain such Enrollee consent to enter the information gathered using the CANS Tool and the determination whether or not the assessed Enrollee is suffering from an SED into the CANS IT System; and

3) Require Behavioral Health Network Providers who do not obtain such Enrollee consent to enter only the determination whether or not the assessed Enrollee is suffering from an SED into the CANS IT System.

e. As directed by EOHHS, the Contractor shall:

1) Establish rates for CPT code 90791 ***with*** modified HA for initial Behavioral Health Clinical Assessments using the CANS Tool for Enrollees under the age of 21 that are at least $15.00 more than the Contractor's rates for CPT code 90791 ***without*** modifier HA; Only pay a Provider for providing Behavioral Health Clinical Assessments using the CANS Tool if such Provider's servicing clinicians are certified in the CANS Tool;

2) Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments and do not bill as a separately billable service the review and updating of the assessment that is required every 90 days for Enrollees in ongoing, individual, group, or family therapy since such review and updating is part of treatment planning and documentation; and

3) Ensure that its Providers have the ability to access and use the CANS IT System and data contained therein, and shall, as further directed by EOHHS, participate in any testing or development processes as necessary for EOHHS to build the CANS IT System.

f. The Contractor shall ensure that such Provider Contracts require Behavioral Health Providers to submit to the Contractor a written report of all Reportable Adverse Incidents in accordance with **Appendix A**, or in another form and format acceptable to EOHHS.

3. Network Hospitals

a. The Contractor shall develop, implement, and maintain protocols with each Network hospital that support the coordination of Enrollees' care, as part of the Contractor's Transitional Care Management program as described in **Section 2.5.C.2**.

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

1) Emergency Department (ED) Services

a) The hospital must notify the Enrollee's PCP within one business day of the Enrollee's presentment at a hospital's ED. Notification may include a secure electronic notification of the visit.

b) The hospital shall offer ESP Services to all members presenting with a behavioral health crisis in the ED.

c) 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) Notification of Inpatient Admission and Discharge Planning Activities

a) The hospital must notify the Enrollee's PCP 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.

b) The hospital, when possible, must begin Discharge Planning on the first day of the Enrollee's inpatient admission.

c) In addition to satisfying all other requirements for Discharge Planning:

(i) The hospital shall ensure that the hospital's discharge summary is sent to the Enrollee's PCP within two business days of the discharge. The discharge summary must 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.

(ii) 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 case managers, caregivers, and other critical supports for the Enrollee.

d) The hospital must document in the Enrollee's medical record all actions taken to satisfy the notification and Discharge Planning requirements set forth in this **Section 2.7.C.3.b**.

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

4) 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.

D. Provider Payments

The Contractor's payments to Network Providers shall be consistent with the provisions of this Section:

1. Timely Payment to Providers

The Contractor shall make payment on a timely basis to Providers for MCO 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:

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

b. Pay 99% of all Clean Claims from Providers within 60 days from the date the Contractor receives the Clean Claim;

c. Submit a Claims Processing annual report in accordance with **Appendix A**; and

d. 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. 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.

a. The Provider shall not profit from provision of MCO Covered Services that are not Medically Necessary or medically appropriate.

b. The Contractor shall not profit from denial or withholding of MCO Covered Services that are Medically Necessary or medically appropriate.

c. Nothing in this Section shall be construed to prohibit 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 **paragraph 5**, below.

3. EOHHS may, in its discretion, direct the Contractor to establish payment rates that are no greater than a certain percentage of the MassHealth Fee-For-Service (FFS) rate or another payment rate specified by EOHHS. Such maximum payment rate shall not be less than 100% of the MassHealth FFS rate. EOHHS may approve an exemption from any such requirement upon the Contractor's written request, which shall include the reason(s) why it is necessary for the Contractor to pay a higher rate, such as in order for the Contractor to implement value-based payment arrangements. Nothing in this Section shall relieve the Contractor of its obligations to ensure access to MCO Covered Services in accordance with **Section 2.9** of this Contract.

4. Current Procedural Terminology Codes and Payment to Providers for Behavioral Health Services

The Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for behavioral health services set forth in **Appendix C** as most recently

adopted by the American Medical Association and CMS and shall pay no less than the MassHealth rate for such CPT codes;

5. The Contractor shall ensure Provider payments are consistent with the provisions set forth in **Sections 2.7.B.2.d.1 and 2.7.B.2.d.2**;

6. Payment rates for hospitals

   a. The Contractor's provider agreements with hospitals shall provide for payment equal to or less than 100% of MassHealth-equivalent rates under Sections 5.B.1 through 5.B.3, 5.B.6, 5.B.7, 5.C.1, and 5.D.7 of the MassHealth Acute Hospital Request For Application (RFA) (subject to Sections 8.2 and 8.3 of said RFA, as applicable), with the exception of Emergency and Post-Stabilization Services (which are governed by **Section 2.6.G** of this Contract) and Behavioral Health services. This maximum payment rate shall not apply if:

      1) A higher rate is necessary for the Contractor to retain its ability to reasonably manage risk or necessary to accomplish the goals of this Contract (e.g., meet access and availability standards or an EOHHS-approved APM). The Contractor shall report any such provider agreements to EOHHS for approval and explain the reason(s) such payments are necessary, in accordance with **Appendix A**;

      2) The provider agreement is with a specialty cancer hospital; or

      3) The provider agreement is a provider agreement described in Section 2.7.D.6.b below.

   b. Unless necessary for the circumstances described in **Section 2.7.D.6.a.1**, the Contractor's provider agreements shall provide for payment equal to 100% of the MassHealth-equivalent rate described in **Section 2.7.D.6.a** above in the following circumstances:

      1) A provider agreement with a freestanding pediatric hospital for an inpatient discharge with a MassHealth DRG Weight of 3.5 or greater; and

      2) A provider agreement with the hospital with a pediatric specialty unit, as defined in the RFA, for Enrollees under the age of 21 at the time of admission for an inpatient discharge with a MassHealth DRG Weight of 3.5 or greater.

7. Minimum payment rates for Certain Behavioral Health Services

   a. For each Behavioral Health service listed in Appendix T, the Contractor shall not enter into provider agreements that provide for payment below the rate specified by EOHHS in **Appendix T** for that service, unless **Section 2.15.M** requires a higher rate.

   b. The Contractor shall provide specialized inpatient psychiatric services to Enrollees under the age of 21 with Autism Spectrum Disorder or Intellectual or Developmental

Disability (ASD/IDD) in specialized ASD/IDD inpatient psychiatric treatment settings, as directed by EOHHS:

1) The Contractor shall report claims paid for psychiatric inpatient services delivered to Enrollees under the age of 21 in specialized ASD/IDD inpatient psychiatric treatment settings to EOHHS in a form and format and at a frequency to be determined by EOHHS;

2) The Contractor shall pay providers no less than the rate specified by EOHHS for inpatient psychiatric services delivered to Enrollees under the age of 21 with ASD/IDD in specialized ASD/IDD inpatient psychiatric treatment settings;

3) For each bed day paid for by the Contractor for the services in **Section 2.5.A.13.a**, EOHHS shall administer an additional per diem payment to the Contractor as set forth in **Section 4.3.C** and **Appendix D.**

c. For Case Consultation, Family Consultation, and Collateral Contact services delivered to Enrollees under the age of 21, the Contractor shall:

1) Establish a 15-minute rate at or above one quarter of the 60 minute rate the Contractor sets for providers for outpatient Individual Treatment, or the amount set forth in Appendix T, whichever is higher; and

2) Revise procedure codes, service definitions, Medical Necessity criteria, and Authorization requirements for Case Consultation, Family Consultation, and Collateral Contact in consultation with and as directed by EOHHS.

d. For Acute Treatment Services for Substance Use Disorders (Level 3.7), delivered on or after October 1, 2018, the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS unless otherwise directed by EOHHS.

e. For Clinical Stabilization Services for Substance Use Disorders (Level 3.5) delivered on or after October 1, 2018, the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS unless otherwise directed by EOHHS.

f. For Applied Behavioral Analysis (ABA Services), the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 358, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

g. For Residential Rehabilitation Services, the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

h. For Population-Specific High Intensity Residential Services (ASAM Level 3.3.), the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

i. For Program of Assertive Community Treatment services (PACT), the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

j. For the Behavioral Health Services described in **Section 2.7.A.3.f-i**, the Contractor shall establish provider rates and use procedure codes as set forth in those sections.

k. The Contractor's payment rates to inpatient psychiatric hospitals for Enrollees placed on AND status should be adequate to maintain the ongoing provision of appropriate clinical care until date of discharge.

8. [Reserved].

9. Non-Payment and Reporting

a. Non-Payment and Reporting of Serious Reportable Events

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" (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;

2) The Contractor shall notify EOHHS of SREs, in accordance with **Appendix A** and guidelines issued by the Department of Public Health (DPH); and

3) The Contractor shall provide EOHHS an annual 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;

b. Non-Payment and Reporting of Provider Preventable Conditions

1) The Contractor agrees to 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 Section 2702 of the Patient Protection and Affordable Care Act and regulations promulgated thereunder;

2) In accordance with 42 CFR 438.3(g), the Contractor shall:

a) 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

b) 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**;

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 CFR 434.6(a)(12), 42 CFR 438.3(g), and 42 CFR 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

a) The Contractor shall not pay a Provider for a Provider Preventable Condition;

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

c) 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;

d) A Contractor may limit reductions in Provider payments to the extent that the following apply:

(i) The identified Provider-Preventable Condition would otherwise result in an increase in payment; and

(ii) The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition;

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

c. Non-Payment and Reporting of Preventable Hospital Readmissions

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;

10. Fluoride Varnish

a. The Contractor shall provide additional reimbursement for the application of Fluoride Varnish by Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses), when provided to eligible MassHealth Members under age 21, during a pediatric preventive care visit where the service is Medically Necessary as determined by a Caries Assessment Tool (CAT);

b. In order to qualify for the additional reimbursement, the Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses) must be certified by either self-administering the American Academy of Pediatrics (AAP) Oral Health Group's online training on Cavity Risk Assessment at http://www.aap.org/commpeds/dochs/oralhealth/cme or the Smile for Life program at www.stfm.org/oralhealth; or attending an instructor-led training session at a time and location to be announced by EOHHS;

c. The Contractor shall require that all PCPs indicate to the Contractor, upon request, whether they are certified to provide Fluoride Varnish and to notify the Contractor of any change in their certification status; and

d. The Contractor shall instruct PCPs who are not certified to direct or refer their patients who need Fluoride Varnish to the Contractor for assistance in finding a certified Provider;

E. Provider Directory and Other Information

1. Provider directory

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

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

1) Alphabetical Provider list, including any specialty and group affiliation as appropriate;

2) Geographic list of Providers by town;

3) Office address and telephone numbers for each Provider, as well as website URL as appropriate;

4) Office hours for each Provider;

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;

6) Whether or not the Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment;

7) For Providers, whether they have open or 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;

8) For Behavioral Health Providers, required information also includes qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use); and

9) Whether the Provider is part of an MCO-Administered ACOs with which the Contractor has an Approved ACO Agreement.

b. For ancillary services Providers:

1) Alphabetical Provider list; and

2) Geographic list of Providers by town.

c. For pharmacies:

1) Alphabetical listing of the pharmacy chains included in the Contractor's network;

2) Alphabetical listing of independent pharmacies, including addresses and phone numbers;

3) Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line for assistance in finding a convenient pharmacy; and

4) The information in **Section 2.7.E.1.a** above.

2. The Contractor shall provide EOHHS with an updated electronic submission of its Provider directory (or directories) on a semi-annual basis, if updated, and an electronic submission of changes to the Provider Network monthly.

3. The Contractor shall provide the Provider directory to its Enrollees as follows:

    a. The Contractor shall provide a copy in paper form to Enrollees upon request. The Contractor shall update its paper-version of its Provider directory monthly if the Contractor does not have a mobile-enabled, electronic directory as further specified by EOHHS and quarterly if the Contractor has such mobile-enabled electronic directory as further specified by EOHHS;

    b. The Contractor shall include written and oral offers of such Provider directory in its outreach and orientation sessions for New Enrollees; and

    c. The Contractor shall include an electronic copy of its Provider directory on the Contractor's website in a machine-readable file and format. The Contractor shall update its electronic version of its Provider directory no later than 30 calendar days after being made aware of any change in information.

4. The Contractor shall provide to EOHHS, in accordance with **Appendix A** and as requested by EOHHS, an ad hoc report of all rates paid to a parent organization or a subsidiary in the previous Contract Year;

5. As requested by EOHHS, the Contractor shall, in a form and format specified by EOHHS, report to EOHHS its Network Providers and whether each provider is enrolled as a MassHealth provider;

6. The Contractor shall develop, maintain and update the following additional data regarding Providers, including, but not limited to, PCPs and Behavioral Health Providers, with areas of special experience, skills, and training including, but not limited to, Providers with expertise in treating: children, adolescents, people with HIV, homeless persons, people with disabilities, people with Autism Spectrum Disorder, people who are deaf or hard-of-hearing, people who are blind or visually impaired, and children in the care or custody of DCF or youth affiliated with DYS (either detained or committed). The Contractor shall make such information available to EOHHS, Members, and Enrollees, upon request.

7. The Contractor shall provide to an Enrollee directly, or through referral, publicly available information maintained by the Massachusetts Board of Registration in Medicine (BORIM) and the National Practitioner Databank on the malpractice history of any Provider(s), upon an Enrollee's request;

8. The Contractor shall demonstrate to EOHHS, by reporting annually in accordance with **Appendix A**, that all Providers within the Contractor's Provider Network are credentialed according to **Section 2.8.H**. of the Contract;

9. Provider Network Changes

    a. The Contractor shall provide notice to EOHHS of significant changes (additions or deletions) in the operations of the Provider Network and significant to the Provider Network itself, that will affect the adequacy and capacity of services. At the time of

any change that (a) prevents the Contractor from complying with **Sections 2.7.A. and B**.; and (b) meets the requirements of **Section 2.7.F.2,** below, the Contractor shall provide immediate written notice to EOHHS, with the goal of providing notice to EOHHS at least 60 days prior to the effective date of any such change. Such notice shall be in the form and format specified by EOHHS and the Contractor shall provide EOHHS will all requested information about the significant change;

b. Significant changes requiring notification include, but are not limited to, the following:

1) Changes in the operations of the Provider Network that result from EOHHS changes in MCO Covered Services, and Provider or Material Subcontractor payment methodology;

2) Enrollment of a new population in the Contractor's Plan;

3) Any termination or non-renewal of a hospital, community health center or community mental health center contract;

4) Any termination or non-renewal of a PCP contract;

5) Any termination or non-renewal of a Behavioral Health Provider or specialist contract that results in there being no other, or a limited number of, PCPs, PCP sites, Behavioral Health Providers or specialists available in a particular part of the Region; or

6) Obstetrics/Gynecology access in a particular part of a Region that decreases below ratios specified in **Sections 2.9.B. and C**;

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

d. For Behavioral Health Provider Network significant changes, the Contractor shall notify EOHHS of the number of affected Enrollees, and the specific steps the Contractor is taking to assure that such Enrollees continue to have access to Medically Necessary Services;

e. The Contractor shall provide to EOHHS a written summary of all significant change(s) with its next Annual Summary of Access and Availability report set forth in **Appendix A**, and in the time frames specified in **Appendix A**, that describes the issues, the steps taken to date to assure that Enrollees have access to Medically Necessary services, and any relevant next steps; and

f. In the event that a Provider leaves or is terminated from the Contractor's Network, the Contractor shall follow the process set forth by EOHHS for communicating with and, as appropriate, transitioning Enrollees affected by the termination. Such process shall include developing a member communication and outreach plan and a provider

communication and outreach plan, and performing other activities EOHHS determines necessary;

10. The Contractor shall report to EOHHS in accordance with **Appendix A** and as a component of the Annual Summary of Access and Availability report set forth in **Appendix A**, all PCPs, including groups, health centers, and individual physician practices and sites, which are not accepting new patients and have been granted the ability to do so by the Contractor;

F. Social Innovation Financing for Chronic Homelessness Program

The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall support the SIF Program as described in this Section.

1. The Contractor shall enter into good faith negotiations with SIF Program providers identified by EOHHS and, provided such negotiations are successful, execute and maintain Network Provider contracts with such SIF Program providers to provide Community Support Program (CSP) services as set forth in **Appendix C** and below; provided, however, that such providers must meet all applicable Contract, statutory, and regulatory requirements. The Contractor shall pay its contracted SIF Program providers a case rate consistent with the current market rate for the services in **Section 2.7.F.3** below for each day an Enrollee is a SIF Program participant.

2. SIF Program participants shall be those Enrollees who the SIF Intermediary refers to the Contractor (a "referral"). The Contractor shall accept from the SIF Intermediary referrals that identify Enrollees, including veterans, who are SIF Program participants. Such referrals shall only be for Enrollees who either:

    a. Meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, i.e. is an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or

    b. Are identified by SIF Program providers and approved by the SIF Intermediary as an individual who is homeless and a high-cost user of emergency services.

    The Contractor may also work with the SIF Intermediary and SIF Program providers to develop a process for the Contractor to refer Enrollees to the SIF Intermediary and SIF Program providers who the Contractor believes may qualify to be SIF Program participants.

3. Subject to Medical Necessity requirements, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall authorize, arrange, coordinate, and provide to Enrollees who are SIF Program participants Community Support Program (CSP) services as set forth in **Appendix C** in a manner consistent with the goals of the SIF Program. Such CSP services shall consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include:

a. Assisting SIF Program participants in enhancing daily living skills;

b. Providing service coordination and linkages;

c. Assisting SIF Program participants with obtaining benefits, housing and healthcare;

d. Developing a crisis plan;

e. Providing prevention and intervention; and

f. Fostering empowerment and recovery, including linkages to Peer Supports and self-help groups.

4. The Contractor shall work with EOHHS to take all steps and perform all activities necessary to implement the above requirements consistent with SIF Program goals, policies and procedures as communicated by EOHHS, including but not limited to participating in meetings with the SIF Intermediary.

G. Community Support Program (CSP) Services for Chronically Homeless Individuals

Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP services as set forth in **Appendix C** to chronically homeless individuals as described in this Section.

1. The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in **Appendix C** to Enrollees who are Chronically Homeless that consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include:

a. Assisting in enhancing daily living skills;

b. Providing service coordination and linkages;

c. Assisting with obtaining benefits, housing and healthcare;

d. Developing a crisis plan;

e. Providing prevention and intervention; and

f. Fostering empowerment and recovery, including linkages to Peer Supports and self-help groups.

2. For the purposes of this **Section 2.7.G,** Chronically Homeless Enrollees shall be those Enrollees who meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

3. The Contractor shall, as further directed by EOHHS, including but not limited to in Managed Care Entity Bulletins, with respect to CSP-CHI:

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

    b. Require that Network Providers of CSP-CHI have demonstrated experience and employed staff as further specified by EOHHS;

    c. Develop Performance Specifications for the delivery of CSP-CHI as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

    d. Ensure that rates paid for CSP-CHI 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;

    e. Report to EOHHS about its network providers of CSP-CHI in accordance with **Appendix A**;

    f. Designate a single point of contact for CSP-CHI to provide information to CSP-CHI providers and EOHHS as further specified by EOHHS; and

    g. Collect and maintain written documentation that the Enrollees receiving CSP-CHI are chronically homeless as further specified by EOHHS.

Section 2.8 Network Management

A. General Requirements

The Contractor shall:

1. Develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, the principles of rehabilitation and recovery for Behavioral Health Services, Cultural and Linguistic Competence, and cost effectiveness. The management strategy shall address all Providers. Such strategy shall include at a minimum:

    a. A system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

    b. 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

c. Conducting on-site visits to Network Providers for quality management and quality improvement purposes;

2. Ensure that its Provider Network is adequate to assure access to all MCO Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the MCO Covered Services;

3. Ensure that Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this Contract;

4. Monitor and enforce access and other Network standards required by this Contract and take appropriate action with Providers whose performance is determined by the Contractor to be out of compliance;

5. Demonstrate, through reports specified in **Appendix A**, that it satisfies the following requirements. The Contractor shall submit such reports at the frequency specified in **Appendix A** and no less frequent than at the time it executes this Contract, on an annual basis, and at any time there is a significant change, as defined by EOHHS, in the Contractor's operations that would affect the adequacy of capacity and services.

   a. Offers an appropriate range of preventive/primary care and specialty services that is adequate for the anticipated number of Enrollees throughout the Contractor's Regions; and

   b. Maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees throughout the Contractor's Regions, as defined in **Section 2.8.B.** below;

6. Operate a toll-free telephone line for Provider inquiries during normal business hours for a minimum of eight hours per day, Monday through Friday, and have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of Urgent or Emergency Services provided, however, that the Contractor and its Providers shall not require such verification prior to providing Emergency Services;

7. Maintain and distribute a Provider Manual(s), which includes specific information about MCO Covered Services, Non-MCO 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 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:

   a. Enrollee rights, including those in **Section 5.1.L**, and the requirement that Enrollees must be allowed to exercise such rights without having their treatment adversely affected;

   b. Provider responsibilities, especially those that apply to Enrollee rights;

c. 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;

d. Enrollee privacy matters;

e. Provider responsibility for assisting Enrollees with interpreter services;

f. Provider obligation to accept and treat all Enrollees regardless of race/ethnicity, age, English proficiency, sexual orientation, health status, or disability;

g. General rules of Provider-Enrollee communications;

h. MCO Covered Services lists;

i. Provider obligation to make Enrollees aware of available clinical care management options and all available care options;

j. An explanation to all Providers that in certain situations minors under the law may consent to medical procedures without parental consent;

k. Permissible Provider Marketing activities in accordance with **Section 2.11.B.;**

l. That in addition to the general prohibitions against charging Enrollees in **Sections 2.7.B** of this Contract, Providers may not charge Enrollees for any service that (a) is not a Medically Necessary MCO or Non-MCO Covered Service; (b) that there may be other MCO Covered Services or Non-MCO Covered Services that are available to meet the Enrollee's needs; and (c) where the Provider did not explain items (a) and (b) and (c), 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;

m. Information on Advance Directives;

n. The Contractor's authority to audit the presence of Advance Directives in medical records;

o. Services that need PCP referrals or prior authorization;

p. Enrollee rights to access and correct medical records information;

q. The process through which the Contractor communicates updates to policies (for Providers and subcontractors);

r. Timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

s. The process and timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

t. Protocols for transitioning Enrollees from one Behavioral Health Provider to another;

u. Coordination between Behavioral Health Providers and PCPs;

v. Coordination between Behavioral Health Providers and state agencies, including but not limited to, DCF, DYS, DMH, DTA and local education authorities;

w. Provider responsibility for submission of Notification of Birth (NOB) forms;

x. Steps a Provider must take to request disenrollment of a Member from his/her panel;

y. Information on the Contractor's administrative appeals process; and

z. 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;

8. Maintain a protocol that shall facilitate communication to and from Providers and the Contractor, and which shall include, but not be limited to, a Provider newsletter and periodic Provider meetings;

9. Except as otherwise required or authorized by EOHHS or by operation of law, ensure that Providers receive 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;

10. Work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Goals and Quality Measures and all other requirements of this Contract;

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

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 Agreements and single case agreements. Such policies and procedures shall include, but may not be limited to, how the Contractor:

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

b. 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.

B. Primary Care Provider (PCP) Network

1. The Contractor shall report to EOHHS annually, or upon EOHHS request, in accordance with **Appendix A**, the following:

a. A geographic access report for adult PCPs and pediatric PCPs demonstrating access by geography (see **Appendix A**); and

b. A PCP-to-Enrollee ratio report showing open and closed adult PCPs and pediatric PCPs per number of Enrollees (see **Appendix A**).

2. The Contractor shall make best efforts to ensure that PCP turnover does not exceed 7% 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 7%, the Contractor shall submit an explanation for the turnover rate to EOHHS and shall propose a corrective action plan in accordance with **Section 5.3.L.** for EOHHS's review and approval.

3. In collaboration with, and as further directed by EOHHS, the Contractor shall develop and implement quality improvement activities directed at:

a. Informing PCPs about the most effective use of the EOHHS-approved standardized behavioral health screening tools;

b. How to evaluate behavioral health information gathered during screenings conducted by Network Providers, such as how to evaluate the results from a behavioral health screening tool;

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

d. 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; and

e. Use of data collected to help delivery of EPSDT screenings, including assuring that PCPs offer behavioral health screenings according to the EPSDT Periodicity Schedule and more often as requested and Medically Necessary.

4. The Contractor shall provide education and training at least annually 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.

5. The Contractor shall submit a quarterly report to EOHHS, in the form and format found in **Appendix A**, by the last day of the month, or the next business day if the last day is not a business day, following the end of each quarter, documenting the number of EPSDT behavioral health screenings provided to Enrollees during the quarter.

6. In accordance with the guidelines established by the Psychotropic Medications in Children Workgroup, the Contractor shall monitor and analyze the prescribing of psychiatric medications in children under the age of 19. Such monitoring and analyzing shall include:

    a. Establishing policies and procedures to identify and monitor psychopharmacologic outlier prescribing patterns by PCPs and other prescribers; and

    b. Establishing criteria, policies and procedures to offer review, consultation, support and Behavioral Health referral resources to the prescriber, as determined appropriate by the Contractor.

7. 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.

8. The Contractor shall, at the direction of EOHHS, require its PCPs who are not MassHealth Primary Care Clinicians (PCCs) to complete a practice infrastructure survey provided by EOHHS.

C. Behavioral Health Requirements

1. Substance Use Disorder Treatment Providers

    a. 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.

    b. The Contractor shall require all substance use disorder treatment Providers to track, by referral source:

        1) All referrals for services;

        2) The outcome of each referral (i.e., admission, etc.); and

        3) If the substance use disorder treatment Provider refuses to accept a referral, the reason for the refusal.

2. State-Operated Community Mental Health Centers (SOCMHCs)

    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, Exhibit 2**, for a list of SOCMHCs, which may be updated by EOHHS from time to time.

3. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Children's Behavioral Health Initiative (CBHI) network. The Contractor shall:

a. Inform EOHHS in writing of authorization procedures for Behavioral Health Services for Enrollees under 21 who are receiving CBHI Services, and of any changes to such authorization procedures prior to their implementation. The Contractor shall assist Providers in learning how to utilize the Contractor's authorization procedures with respect to CBHI Services. The Contractor shall monitor its authorization procedures to ensure that the procedures provide for timely access to CBHI Services. In the event that the Contractor's authorizations procedures with respect to CBHI Services result in delays or barriers to accessing Medically Necessary services, the Contractor shall modify such authorization procedures;

b. Ensure that the authorization procedures established for ICC and Family Support and Training allow for at least the first 28 days to occur without prior approval. The Contractor may establish notification or registration procedures during the first 28 days of ICC;

c. Ensure that its authorization procedures comply with all provisions of **Section 2.6.C** of the Contract and, in addition, that all authorization approvals for ICC and Family Support and Training are provided at the time of the provider request;

d. Ensure that ICC and Family Training and Support Services are delivered according to both the program specifications and the EOHHS-approved ICC Operations manual. In the event that there are discrepancies between the two documents, performance specifications shall control and the Contractor shall notify EOHHS of any discrepancies for correction;

e. Assign a single point of contact for management of the CBHI network. The Contractor's single point of contact's responsibilities shall include, but not be limited to, providing in person technical assistance to Providers who provide CBHI Services to answer questions regarding authorization of services and assisting Providers in facilitating and ensuring that the Providers engaged in a youth's treatment will participate in all care plan/treatment meetings;

f. Ensure that Providers' staff participate in CBHI training, coaching and mentoring provided by EOHHS's CBHI training vendor, including on-site activities, distance learning, and Quality Improvement activities recommended by the training vendor. The Contractor shall ensure that Providers' staff completes the CBHI training, coaching and mentoring tasks assigned by the training vendor, and utilizes their new skills in service delivery. If the Provider is not participating in the training vendor's activities, the Contractor shall engage in Provider Network Management activities to increase participation;

g. Ensure that each CSA develops and coordinates a local systems of care committee to support each CSA's efforts to establish and sustain collaborative partnerships among families and community stakeholders in its geographic area. The Contractor shall assign a staff person who shall participate in the local systems of care committees as

agreed to in collaboration with all MassHealth managed care entities and shall attend monthly meetings of the committees for the first year of the CSA implementation;

h. Ensure that providers of CBHI Services provide each such service in accordance with all EOHHS approved CBHI Services performance specifications and CBHI Services Medical Necessity Criteria; and

i. Develop specific quality management activity plans for providers of CBHI Services;

4. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Residential Rehabilitation Services for Substance Use Disorders (RRS) network. The Contractor shall:

a. As further directed by EOHHS and in accordance with all other applicable Contract requirements, contract with all qualified, licensed RRS providers willing to accept the rate specified by EOHHS;

b. The Contractor shall support each RRS provider's efforts to establish and sustain collaborative partnerships among service providers and community stakeholders in its geographic area;

c. Ensure that RRS is provided in accordance with EOHHS- approved RRS performance specifications and RRS Medical Necessity Criteria which shall align with the American Society for Addiction Medicine (ASAM) criteria;

d. Submit for EOHHS's approval authorization and concurrent review procedures for RRS and any changes to such authorization and concurrent review procedures prior to their implementation. The Contractor shall:

1) Utilize the American Society for Addiction Medicine (ASAM) criteria as the basis for establishing authorization and concurrent review procedures;

2) Assist RRS Providers in learning how to utilize the Contractor's authorization and concurrent review procedures with respect to RRS;

3) 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;

e. Assign a single point of contact for management of the RRS network. The Contractor's single point of contact's responsibilities shall include, but not be limited to, providing in- person technical assistance to RRS Providers to answer questions regarding billing and authorization of services and assisting RRS Providers in facilitating and ensuring

that Enrollees are connected to other services as indicated by the Enrollees treatment plan; and

f. For RRS, establish Provider rates and use procedure codes as set forth in **Section 2.7.D.7**.

5. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing Recovery Coach services, as described in Appendix C. The Contractor shall:

a. As directed by EOHHS and in accordance with all other applicable Contract requirements, contract with all qualified providers seeking to join the Contractor's Provider Network to provide Recovery Coach services;

b. Ensure that Recovery Coach services are provided in accordance with all EOHHS approved Recovery Coach performance specifications and Recovery Coach Medical Necessity Criteria;

c. Adopt authorization, concurrent review, notification or registration procedures, and documentation parameters for Recovery Coaches in accordance with a uniform standard established by EOHHS. The Contractor shall:

1) Assist Providers in learning how to utilize the Contractor's authorization and concurrent review procedures with respect to Recovery Coach services;

2) Ensure that the authorization procedures established for Recovery Coach services allow for at least the first 60 days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 60 days of Recovery Coach services as specified by EOHHS;

d. For Recovery Coach services, establish Provider rates and use procedure codes as set forth in Section 2.7.D.7.

6. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Recovery Support Navigator network, as described in Appendix C. The Contractor shall:

a. As directed by EOHHS and in accordance with all other applicable Contract requirements, contract with all qualified providers seeking to join the Contractor's Provider Network to provide Recovery Support Navigator services;

b. Ensure that Recovery Support Navigator services are provided in accordance with all EOHHS approved Recovery Support Navigator performance specifications and Recovery Support Navigator Medical Necessity Criteria;

c. Adopt authorization, concurrent review, notification or registration procedures, and documentation parameters for Recovery Support Navigators in accordance with a uniform standard established by EOHHS. The Contractor shall:

1) Assist Providers in learning how to utilize the Contractor's authorization and concurrent review procedures with respect to Recovery Support Navigator services;

2) Ensure that the authorization procedures established for Recovery Support Navigator 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 Support Navigator services as further specified by EOHHS;

d. For Recovery Support Navigator services, establish Provider rates and use procedure codes as set forth in Section 2.7.D.7.

7. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Population-Specific High Intensity Residential Services (ASAM Level 3.3) network, as described in Appendix C. The Contractor shall:

a. As directed by EOHHS, ensure that that Population-Specific High Intensity Residential Services (ASAM Level 3.3.) are provided in accordance with all EOHHS approved Population-Specific High Intensity Residential Services performance specifications and Medical Necessity criteria;

b. As directed by EOHHS, establish Provider rates and use procedure codes as set forth in Section 2.7.D.7.

8. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Opioid Treatment Program (OTP) network. The Contractor shall:

a. Cover and pay for the administering and dispensing of methadone, buprenorphine, and naltrexone through its OTP Network Providers. If the Contractor utilizes a Material Subcontractor for Behavioral Health Services, cover and pay for such services solely through such Material Subcontractor and require such Material Subcontractor to comply with the requirements in this **Section 2.8.C.8**;

b. Use the codes specified by EOHHS for the coverage of methadone, buprenorphine, and naltrexone and related services when delivered by OTP Network Providers; and

c. Ensure that OTP Network Providers follow the MassHealth ACPP/MCO Uniform Preferred Drug List for any drugs related to the provision of OTP.

9. 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:

    a. Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric Units within General Hospitals

    b. Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

    c. Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)

    d. Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

    For reference, excerpts of DMH Licensing Division Bulletin #19-01, including the relevant Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards, are reprinted in **Appendix G, Exhibit 5**. In the event that the Department of Mental Health amends or supersedes DMH Licensing Division Bulletin #19-01, the amended or superseding bulletin shall be controlling.

10. 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.

11. For Contract Year 2020, as directed by EOHHS, the Contractor shall submit to EOHHS for review and feedback a strategic plan to identify and address challenges, including challenges identified by EOHHS, with CBAT and ICBAT programs and related population needs. Such strategic plan shall be in a form and format specified by EOHHS and include, at a minimum, components specified by EOHHS, including but not limited to how the Contractor will extend additional financial resources to providers of CBAT and ICBAT programs totaling a 20% increase in financial resources to these programs. The Contractor shall report to EOHHS at the end of the Contract Year in accordance with **Appendix A** on its progress in implementing its strategic plan, including reporting on the incremental year over year expenditures on ICBAT and CBAT services.

D. Behavioral Health Clinical Assessment and Treatment Planning

The Contractor shall:

1. Ensure that all Behavioral Health Providers prepare an individualized written Behavioral Health Clinical Assessment and treatment plan for all Enrollees starting behavioral health treatment and for Behavioral Health Services to be provided upon discharge from any level of behavioral health care;

2. Ensure that the Behavioral Health Clinical Assessments are conducted by behavioral health Providers who have training and experience that match the Enrollee's clinical needs based on their presenting behavioral health problem(s) and diagnosis;

3. Require and monitor that Behavioral Health Clinical Assessments and treatment plans are completed within the time frames set forth below:

    a. Acute inpatient treatment: within 24 hours of admission;

    b. 24-Hour Diversionary Services: within 24 hours of admission;

    c. Non-24-Hour Diversionary Services: by the end of the second visit; and

    d. Behavioral Health Outpatient Services: in accordance with DPH regulation 105 CMR 140.540;

4. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers are in writing, dated and signed, and include, at a minimum, the following:

    a. History of presenting problem;

    b. Chief complaints and symptoms;

    c. Strengths of the Enrollees and caregivers that will be used in treatment planning;

    d. Past mental health and/or substance use disorder history;

    e. Past medical history;

    f. Family, social history and linguistic and cultural background;

    g. Current substance use disorders;

    h. Mental status exam;

    i. Present medications and any allergies;

    j. Diagnosis;

    k. Level of functioning;

    l. Treatment plan;

m. Crisis assessment planning;

n. Name of and contact information for the PCP;

o. Clinical formulation, rationale for treatment, recommendations and strengths; and

p. Use of the CANS Tool for Enrollees under age 21 and for Enrollees age 21 and over, other behavioral health screening tools identified and approved by EOHHS;

5. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers for individuals under age 21, where the CANS Tool is required, are provided by Behavioral Health Providers who are certified CANS Providers;

6. Ensure the ability to access and use the CANS IT System and data contained therein, and shall, as further directed by EOHHS, participate in any testing or development processes as necessary for EOHHS to build the CANS IT System;

7. In collaboration with and as further directed by EOHHS, develop and implement network quality improvement activities directed at ensuring that Network Providers are using the CANS Tool in their Behavioral Health Clinical Assessments for Enrollees under the age of 21; and can access and utilize the CANS IT System to input CANS assessments;

8. Require and monitor compliance with the following:

   a. That a Behavioral Health Multidisciplinary Team is assigned to each Enrollee within 24 hours of an acute Behavioral Health Inpatient or 24-Hour Diversionary Services admission;

   b. That the Behavioral Health Multidisciplinary Team meets and reviews the Enrollee's treatment plan within 24 hours of an acute Behavioral Health Inpatient Services admission or 24-Hour Diversionary Services admission, modifies the treatment plans as needed and, during the Enrollee's Behavioral Health Inpatient Services stay, periodically meets to review and modify the treatment plan; and

   c. That the Behavioral Health Multidisciplinary Team reviews facility-based, outpatient care in accordance with 105 CMR 140.540;

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

10. Ensure that for all state agency clients, the treatment plan specifies all Behavioral Health Services required during the acute Behavioral Health Inpatient Services stay, identifies discharge plans and, when appropriate, indicates the need for DMH Community-Based Services;

11. When it is anticipated that the Enrollee's discharge plan shall include DMH Community-Based Services, ensure that the DMH Community-Based Services case managers participate in each treatment team meeting; and

12. Ensure that Enrollees, their guardians, and family members, as appropriate, are included in the development and modification of the Enrollee's treatment plan, in the treatment itself, and that they attend all treatment plan meetings, provided that for adult Enrollees, the Enrollee has rendered their consent for these individuals to participate in the treatment and treatment plan-related activities described herein.

E. Treatment and Discharge Planning at Behavioral Health Inpatient and 24-Hour Diversionary Settings

The Contractor shall implement policies and procedures that (1) ensure timely and effective treatment and Discharge Planning; (2) establish the associated documentation standards; (3) involve the Enrollee and the Contractor; and (4) begin on the day of admission. Treatment and Discharge Planning shall include at least:

1. Identification and assignment of a facility based case manager for the Enrollee. This staff member shall be involved in the establishment and implementation of treatment and Discharge Planning;
2. Identification of the new acute clinical services, as well as supports, covered services and the continuing care with any established Providers, and the identification of any new Providers and the covered services that will be added;
3. Identification of the Enrollee's state agency affiliation, release of information, and coordination with any state agency case worker assigned to the Enrollee;
4. Identification of non-clinical supports and the role they serve in the Enrollee's treatment and after care plans;
5. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards set forth in **Section 2.9.B.2.e**;
6. Recommendation for the initial frequency of aftercare services and supports;
7. Identification of barriers to aftercare and timely discharge of Enrollees, including but not limited to Enrollees on AND, and the strategies developed to address such barriers;
8. Procedures to monitor for the earliest identification of the next available after care resource required for the Enrollee who has remained in the Behavioral Health Inpatient and 24-Hour Diversionary setting for non-medical reasons (e.g., the recommended aftercare resources were not yet available);
9. Assurance that Inpatient and 24-Hour Diversionary Providers provide a discharge plan following any Behavioral Health admission to other providers working with the Enrollee and PCP;
10. Ensure that Providers invite Enrollees' family members, their guardians, outpatient individual practitioners, state agency staff, as appropriate and if applicable, and other identified supports to participate in Discharge Planning to the maximum extent practicable, including behavioral health treatment team meetings, developing the discharge plan, when appropriate, and for adult Enrollees, only when the Enrollee has consented to their involvement;

11. Ensure that services contained in the Enrollee's discharge plan are offered and available to Enrollees within seven business days of discharge from an inpatient setting;

12. Ensure that Enrollees who require medication monitoring will have access to such services within 14 business days of discharge from a Behavioral Health Inpatient setting;

13. Require that Behavioral Health Network Providers, upon admission of an Enrollee:

    a. Assign a case manager or other appropriate staff;

    b. Develop, in collaboration with the Enrollee, including Enrollees on AND, a plan for the Enrollee's discharge to a more appropriate level of care, service or program;

    c. Ensure that the treatment and discharge plan for Enrollees who are state agency clients is coordinated with appropriate state agency staff;

    d. Make best efforts to ensure a smooth transition to the next service or to the community; and

    e. Document all efforts related to these activities, including the Enrollee's active participation in Discharge Planning; and

14. Ensure that a process is in place for identifying Enrollees who remain in an acute inpatient hospital or community based acute treatment and authorized as an Administratively Necessary Day and report to EOHHS as required in **Appendix A**. The Contractor shall produce upon EOHHS request discharge plans for all such Enrollees.

F. Network Management of the Behavioral Health Provider Network

The Contractor shall develop and implement a Behavioral Health Provider Network management strategy that shall include the following:

1. A system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

2. 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;

3. On-site visits to Network Providers for quality improvement purposes;

4. In collaboration with and as further directed by EOHHS, the development and implementation of network quality improvement activities directed at ensuring that Network Providers are using the CANS Tool in their Behavioral Health Clinical Assessments and as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services for Enrollees under the age of 21; and, access and utilize the CANS IT System to input information gathered using the CANS Tool and the determination of whether or not the assessed Enrollee is suffering from an SED; and

G. Cultural and Linguistic Competence

The Contractor shall ensure that:

1. Multilingual Network Providers and, to the extent that such capacity exists throughout the Contractor's Regions, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations;

2. Network Providers and interpreters/transliterators are available for those who are Deaf or hearing-impaired, to the extent that such capacity exists throughout the Contractor's Regions;

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

4. It identifies 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

H. Provider Credentialing, Recredentialing, and Board Certification

1. General Provider Credentialing

The Contractor shall implement written policies and procedures that comply with the requirements of 42 CFR 438.214 regarding the selection, retention and exclusion of Providers and meet, at a minimum, the requirements below. The Contractor shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually in accordance with **Appendix A** that all Providers within the Contractor's Provider Network are credentialed according to such policies and procedures. The Contractor shall:

a. Designate and describe the departments(s) and person(s) at the Contractor's organization who will be responsible for Provider credentialing and re-credentialing;

b. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Providers and all other licensed or certified Providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13. Such processes shall also be consistent with any uniform credentialing policies specified by EOHHS addressing acute, primary, behavioral health Providers (including but not limited to substance use disorder Providers), and any other EOHHS-specified Providers;

c. 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;

d. Maintain a documented re-credentialing process which 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 conducted pursuant to **Section 2.13.C.2,** utilization management information collected pursuant to **Section 2.13.C.3,** and Enrollee satisfaction surveys collected pursuant to **Section 3.1.B.4**;

e. Maintain a documented re-credentialing process that 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 shall also be consistent with any uniform re-credentialing policies specified by EOHHS addressing acute, primary, behavioral health Providers (including but not limited to substance use disorder Providers), and any other EOHHS-specified Providers;

f. 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. In addition:

1) The Contractor shall monitor Providers and prospective Providers by monitoring all of the databases described in **Appendix N**, at the frequency described in **Appendix N** as follows.

a) The Contractor shall search the databases in **Appendix N** 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;

b) 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 N**;

c) The Contractor shall identify the appropriate individuals to search and evaluate pursuant to this Section by using, at a minimum, the Federally Required Disclosures Form provided by EOHHS;

d) 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 2.8.H.1.f.1**. 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, which may include, but shall not be limited to computer screen shots from the databases set forth in **Appendix N**; and

e) The Contractor shall develop and maintain policies and procedures to implement the requirements set forth in this Section.

2) 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 Network as appropriate. In the event EOHHS suspends payment to a provider, including but not limited to when there is an investigation of a credible allegation of fraud, the Contractor shall also suspend such payment, if directed to do so by EOHHS; provided, however, that the Contractor may propose to EOHHS that there is good cause for the Contractor not to suspend, or to suspend in part, such payments for the reasons set forth below. EOHHS shall approve or deny the Contractor's proposal.

a) The Contractor may propose that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to a provider against which there is an investigation of a credible allegation of fraud, for any of the following reasons:

(i) Other available remedies implemented by the Contractor more effectively or quickly protect Medicaid funds.

(ii) The Contractor determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed.

(iii) Enrollee access to items or services would be jeopardized by a payment suspension because either:

(a) The provider is the sole community physician or the sole source of essential specialized services in a community, or

(b) The provider serves a large number of beneficiaries within a HRSA-designated medically underserved area.

(iv) Law enforcement declines to certify that a matter continues to be under investigation.

(v) The Contractor determines that payment suspension is not in the best interests of the Medicaid program.

b) The Contractor may propose that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider against which there is an investigation of a credible allegation of fraud if any of the following reasons:

(i) Enrollee access to items or services would be jeopardized by a payment suspension because either:

(a) The provider is the sole community physician or the sole source of essential specialized services in a community, or

(b) The provider serves a large number of beneficiaries within a HRSA-designated medically underserved area.

(ii) The Contractor determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

(iii) The Contractor can demonstrate both of the following:

(a) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and

(b) The Contractor determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

(iv) Law enforcement declines to certify that a matter continues to be under investigation.

(v) The State determines that payment suspension only in part is in the best interests of the Medicaid program.

3) The Contractor shall notify EOHHS when it terminates, suspends, or declines a Provider from its Network because of the reasons described in subsection (2) above or for any other independent action including for a reason described in this **Section 2.8.H.1**;

4) On an annual basis, the Contractor shall submit to EOHHS a certification checklist set forth in **Appendix A** confirming that it has implemented the actions necessary to comply with this section; and

5) This Section does not preclude the Contractor from suspending or terminating Providers for reasons unrelated to the possible suspension and/or termination from participation in MassHealth, Medicare or another state's Medicaid program;

g. Not employ or contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a Provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901. In addition, pursuant to sections 1903(i), including 1903(i)(2)(B), of the Social Security Act, the Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) 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, title VXIII, or XX or under title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after reasonable time period after reasonable notice has been furnished to the person);

h. Not establish Provider selection policies and procedures that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;

i. 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 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and

j. Search and do not contract with the names of parties disclosed during the credentialing process in the databases in **Appendix N** in accordance with the Contractor's obligations set forth in **Section 2.8.H.1.f.1** and in the MassHealth exclusion list, and parties that have been terminated from participation under Medicare or another state's Medicaid program. The Contractor shall, as of the date indicated in the exclusion database, not contract with or shall terminate a contract with any provider found in the exclusion database;

k. Obtain federally required disclosures from all Network Providers and applicants in accordance with 42 CFR 455 Subpart B and 42 CFR 1002.3, and as specified by EOHHS, 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 2.8.H.1,** and relevant state and federal laws and regulations.

l. Notify EOHHS when a Provider fails credentialing or re-credentialing because of a program integrity reason, including those reasons described in this **Section 2.8.H.1**, and shall provide related and relevant information to EOHHS as required by EOHHS or state or federal laws, rules, or regulations;

m. Develop and maintain policies and procedures that support a process for the recoupment of payments from Providers identified as excluded by appearing on any exclusion or debarment database, including those at **Appendix N**. 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 include outreach to the Provider, voiding claims, and establishing a recoupment account; and

n. As further directed by EOHHS, share information collected pursuant to the credentialing activities described in this Section with EOHHS, including facilitating EOHHS efforts to standardize Provider enrollment or credentialing processes between EOHHS and the Contractor.

o. The Contractor shall terminate a Network Provider for cause as further described in this section.

1) For the purposes of this section:

a) "for cause" shall be defined as reasons related to fraud, integrity, or quality issues that run counter to the overall success of MassHealth as further described in sections (2) and (3) below, and

b) "termination" shall be defined as termination of a Network Provider's privilege to bill the Contractor, of which appeal rights have been exhausted or the time for appeal has expired.

2) Mandatory Termination of Network Provider

The Contractor shall terminate a Network Provider, and such termination shall be considered for cause, in the following cases:

a) Medicare terminates a Network Provider for one of the reasons under 42 CFR 424.535, and such termination which would require EOHHS to terminate such provider from MassHealth;

b) All circumstances set forth in 42 CFR 455.416 where EOHHS would be required to terminate a provider from MassHealth; and

c) All circumstances set forth in 130 CMR 450.212(A)(1)-(5) where EOHHS would be required to terminate a provider from MassHealth.

3) Discretionary Termination of Network Provider

The Contractor may terminate a Network Provider, and the Contractor may consider such terminations to be for cause terminations, in the following cases:

a) As described in 42 CFR 455.416(g), the Network Provider provided false or misleading information or the Contractor is unable to verify the identity of the provider.

b) Other reasons related to fraud, integrity or quality, including when the Network Provider:

(i) Or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the Network Provider is:

(a) Excluded from Medicare, Medicaid, or any other health care program as defined in 42 CFR 1001.2;

(b) Debarred, suspended, or otherwise excluded from participating in any other federal program or activity in accordance with Federal Acquisition Streamlining Act and 45 CFR part 76; or

(c) Subject to any other state or federal exclusion.

(ii) Loses its license as a result of an adverse licensure action

(iii) Abuses billing privileges, such as selling to another its billing number or submitting a claim for services that could not have been furnished (e.g. the physician or Enrollee were not present when the services were supposedly furnished or the equipment necessary to perform a service was not present).

(iv) Has its ability to prescribe drugs suspended or revoked by an applicable federal or state licensing or administrative body or has a pattern of improperly prescribing drugs in a manner that does not meet Medicaid requirements.

(v) Bills for services furnished while its license is suspended.

(vi) Is not in compliance with provider enrollment requirements, including but not limited to those set forth for MassHealth

providers at 130 CMR 450.212(A), or fails any applicable onsite review.

(vii) Otherwise poses a threat of fraud, waste, or abuse.

4) Reporting

The Contractor shall notify EOHHS when it terminates a Provider for cause, as defined above, within three (3) business days of such termination.

2. Board Certification Requirements

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:

a. Require that all applicant physicians, as a condition for participation in the Contractor's Network, meet one of the following, except as otherwise set forth in paragraph b. below:

1) Be board certified in their practicing medical specialty;

2) Be in the process of achieving initial certification; or

3) Provide documentation demonstrating that the physician either is currently board eligible or has been board eligible in the past.

b. If necessary to ensure adequate access, the Contractor may contract with Providers who have training consistent with board eligibility but are neither board certified nor were ever eligible to be 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

c. 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 eligibility.

3. Behavioral Health Provider Credentialing

a. In addition to those requirements described in **Section 2.8.H.1 and 2** above, the Contractor shall implement the Behavioral Health Credentialing Criteria as prior approved by EOHHS;

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

c. For a BH Services Provider that is a hospital that provides Behavioral Health Inpatient Services, ensure that such hospital has a human rights protocol that is consistent with the DMH requirements **Appendix G** and regulations and includes training of the Behavioral Health Provider's staff and education for Enrollees regarding human rights; and

d. For a BH Services Provider that is a hospital that provides Behavioral Health Inpatient Services, 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, in accordance **Appendix G** with DMH regulations and requirements.

4. Laboratory Credentialing

The Contractor shall require, in accordance with the Clinical Laboratory Improvement Amendments (CLIA), all laboratories performing services under this Contract to:

a. Have a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by the U.S. Department of Health and Human Services applicable to the category of examinations or procedures performed by the laboratory;

b. Be CLIA-exempt as defined in 42 CFR 493.2; or

c. Satisfy an exception set forth in 42 CFR 493.3(b)."

I. Provider Profiling

1. The Contractor must conduct profiling activities for PCPs, Behavioral Health Providers and, as directed by EOHHS, other Provider types, at least annually. As part of its quality activities, the Contractor must 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. Provider profiling activities must include, but are not limited to:

a. Developing Provider-specific reports that include a multi-dimensional 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;

b. Establishing Provider, group, or regional benchmarks for areas profiled, where applicable, including MassHealth-specific benchmarks, if any;

c. Providing feedback to Providers regarding the results of their performance and the overall performance of the Provider Network; and

d. 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.

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:

a. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor standards or improvement goals;

b. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures;

c. Conduct on-site visits to Network Providers for quality improvement purposes; and

d. At least annually, measure progress on the Provider Network and individual Providers' progress, or lack of progress, towards meeting such improvement goals.

4. The Contractor shall maintain regular, systematic reports, in a form and format approved by EOHHS, of the above-mentioned Provider profiling activities and related Quality Improvement activities pursuant to **Section 2.13** and **Appendix B**. 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.

J. Provider Education

The Contractor shall establish ongoing Provider education, including but not limited to, the following issues:

1. MCO Covered and Non-MCO Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis shall be placed on areas that vary from many commercial coverage rules (e.g. EPSDT Services, Early Intervention Services, therapies and DME/Medical Supplies);

2. The relevant requirements of this Contract;

3. The Contractor's quality improvement efforts and the Provider's role in such a program;

4. The Contractor's continuity of care policies and procedures, as described in **Section 2.2.C**;

5. The Contractor's policies and procedures, especially regarding in and out-of-network referrals; and

6. For PCPs, education and information on:

a. All EPSDT and PPHSD mandated screenings for children and adolescents up to age 21;

b. Issues of adolescence, including but not limited to, sexual activity, drug and alcohol use, and school and family concerns;

c. Issues, including but not limited to, the following:

1) Pre-conception health concerns, including folic acid administration; family planning guidance; nutrition; osteoporosis prevention; HIV and STD prevention; and HIV testing prior to becoming pregnant; and

2) Pre- and post-menopause concerns, including hormone treatment, osteoporosis, nutrition and cardiac concerns;

d. Issues concerning persons with disabilities, including but not limited to:

1) The needs of persons with disabilities;

2) Assisting Enrollees with disabilities in maximizing Enrollees' involvement in the care they receive, and in making decisions about such care;

3) Providing information on accessing day, therapeutic and supportive services, if applicable (i.e., day habilitation, adult day health, adult foster care, etc.) or other community based services; and

4) Maximizing for Enrollees with disabilities, independence and functioning through health promotion and preventive care, decreased hospitalization and emergency room use, and the Enrollee's ability to be cared for at home, and providing resources and referrals to agencies that specialize in community services for persons with disabilities;

e. Issues concerning adult men and women and regular care that they should be receiving according to the Massachusetts Health Quality Partners (MHQP) Adult Preventive Care Guidelines; and

f. Issues concerning other special populations including the homeless, high-risk pregnant individuals, and children in the care or custody DCF and youth affiliated with DYS (either detained or committed).

7. As directed by EOHHS, the Contractor shall develop and distribute provider bulletins or comparable communications concerning the CBHI or shall coordinate the development and distribution with all other Accountable Care Partnership Plans, MassHealth-contracted MCOs and prepaid inpatient health plans. The content of these communications is subject to prior approval by EOHHS and may be modified in whole or in part at the discretion of EOHHS.

a. With respect to behavioral health screening, the Contractor shall develop and distribute Provider communications that shall give Providers information that describes:

1) The standardized behavioral health screening tools approved by EOHHS;

2) How to provide Medically Necessary treatment services or refer MassHealth Standard and CommonHealth Enrollees under age 21 for Medically Necessary treatment services in accordance with EPSDT requirements;

3) How to provide Medically Necessary treatment services or refer MassHealth Family Assistance Enrollees under age 21 for Medically Necessary treatment services included in their benefit package;

4) 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; and

5) The CBHI Services that will be required including anticipated timelines for implementation.

b. The Contractor shall prepare and disseminate, as directed by EOHHS and subject to EOHHS review and approval, Provider Alerts or similar communications and education materials that explain to Providers:

1) The CANS Tool;

2) The process and procedures for obtaining required CANS training and certification;

3) The process and procedures for accessing and utilizing the CANS IT System;

4) Any processes for billing for Behavioral Health Clinical Assessments using the CANS; and

5) Any other information about Behavioral Health Clinical Assessments using the CANS or the CANS IT System. These communications shall be disseminated to Network Providers who provide the services described in **Section 2.7.C.2.a**, in a timeframe established by EOHHS.

8. As directed by EOHHS, the Contractor shall conduct at least one forum per year to educate PCPs and Behavioral Health Providers about the value of integrated and coordinated service delivery and the importance of primary care and of behavioral health screenings and appropriate referrals to Behavioral Health Providers. If requested or approved by EOHHS, the Contractor shall coordinate these forums with EOHHS or other MassHealth–contracted

Accountable Care Partnership Plans, MCOs, and prepaid inpatient health plans. These forums shall:

a. Include a written curriculum, which shall be prior approved by EOHHS, and may be modified by EOHHS in whole or in part at the discretion of EOHHS;

b. Include at least one forum per year for Behavioral Health Providers on behavioral health topics to be prior approved by EOHHS; and

c. Meet any further requirements, as directed by EOHHS, or that the Contractor determines necessary, to assure that Providers receive accurate information about EPSDT and the CBHI that is prior approved by EOHHS.

9. As directed by EOHHS, the Contractor shall conduct at least one forum per year to encourage clinical performance activities by Behavioral Health Providers consistent with the principles and goals of the CBHI. If requested or approved by EOHHS, the Contractor shall coordinate these forums with EOHHS or other MassHealth-contracted Accountable Care Partnership Plans, MCOs, and prepaid inpatient health plans. These forums shall:

a. Include a written curriculum, which shall be prior approved by EOHHS, and which may be modified by EOHHS, in whole or in part at the discretion of EOHHS; and

b. Meet any further requirements that are directed by EOHHS, or that the Contractor determines necessary, to assure that Providers receive accurate information about EPSDT and the CBHI that have been approved by EOHHS.

10. For all Providers, issues concerning individuals with disabilities, such as cognitive, intellectual, mobility, psychiatric, and sensory disabilities as defined in **Section 1**, including but not limited to:

a. Various types of chronic conditions and disabilities prevalent in Massachusetts;

b. Compliance with the American with Disabilities Act and other federal and state laws related to serving individuals with disabilities;

c. Information related to communication access, medical equipment access, physical access, and access to programs;

d. Types of barriers individuals with disabilities face in the health arena and accommodation and access needs to face such barriers;

e. Person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model;

f. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment; and

g. Peer-run, community-based rehabilitation and long-term support services.

11. EOHHS Delivery System Payment Reform efforts, including but not limited to MCO-Administered ACOs and any implications for Providers.

K. Marketing Activity Requirements

The Contractor shall require that its Providers comply with the Marketing activity requirements found in **Section 2.11** of the Contract.

L. Disability Access Incentive for Acute Hospitals

The Contractor shall:

1. For each Contract Year, collect the following information, in a form and format specified by EOHHS, on a tri-annual basis from its Network Providers who are acute care hospitals:

   a. The Provider's capacity to provide accessible medical and diagnostic equipment to individuals with disabilities;

   b. A detailed list of the Provider's accessible medical and diagnostic equipment;

   c. The Provider's plan to improve its provision of accessible medical and diagnostic equipment for individuals with disabilities;

   d. The name and contact information for the Provider's single point of contact for those seeking or having questions about access for individuals with disabilities (i.e. a Disability Access Key Contact); and

   e. Additional information as specified by EOHHS.

2. Submit to EOHHS, at a time and in a manner specified by EOHHS:

   a. The information the Contractor collected in accordance with **Section 2.8.L.**1 above; and

   b. A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

3. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments at a frequency specified by EOHHS, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to certain providers, identified by EOHHS, that are acute care hospitals that have executed the MassHealth Acute Care Hospital RFA. The Contractor shall make such payments to such providers within 14 calendar days of receiving payment from EOHHS.

M. Hospital Quality Incentive Payment

The Contractor shall:

1. For each Contract Year, collect the following information, in a form and format and at times specified by EOHHS, from Essential MassHealth Hospitals as defined in the Commonwealth's State Plan:

    a. At the time of the midpoint evaluation specified by EOHHS:

        1) Progress on certain hospital quality measures and related performance goals specified by EOHHS; and

        2) Additional information as specified by EOHHS.

    b. At the time of the year end evaluation specified by EOHHS:

        1) Performance information on certain hospital quality measures specified by EOHHS; and

        2) Additional information as specified by EOHHS.

2. Submit to EOHHS, at a time and in a manner specified by EOHHS:

    a. The information the Contractor collected in accordance with **Section 2.8.M.1** above; and

    b. A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

3. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments at a frequency specified by EOHHS, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to Essential MassHealth Hospitals as defined in the Commonwealth's State Plan. The Contractor shall make such payments to such providers within 14 calendar days of receiving payment from EOHHS.

N. Other MCO-directed incentive programs

EOHHS may, in advance of any Contract Year, amend the contract to require the Contractor to administer other value-based incentive payments consistent with 42 CFR 438.6(c).

Section 2.9 Accessibility and Availability

The Contractor shall ensure adequate access to MCO Covered Services for all Enrollees and shall further facilitate access to Non-MCO Covered Services. All such services shall be accessible and available to Enrollees in a timely manner. Accessibility shall be defined as the extent to which the Enrollee can obtain services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. Availability shall be defined as the extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership.

A. General

The Contractor shall:

1. Assure EOHHS that it has the capacity to serve Enrollees in accordance with the access and availability standards specified in **Sections 2.9.B**. and **C**. by submitting reports specified in **Appendix A**, on an annual and ad-hoc basis, and whenever there is a significant change in operations of the Provider Network and significant changes to the Provider Network itself, that would affect the adequacy and capacity of services. Significant changes shall include, but are not limited to:

    a. Changes in MCO Covered Services;

    b. Enrollment of a new population in the Contractor's Plan;

    c. Changes in the Contractor's Regions; and

    d. Changes in Provider payment methodology.

    If the Contractor is not in compliance with the access and availability standards specified in **Sections 2.9.B. and C**., the Contractor shall take corrective action necessary to come into compliance with such access standards; and

2. Ensure access to MCO 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.

B. Accessibility

The Contractor shall ensure that Enrollees have access to MCO Covered Services as provided below.

1. Physical Health Services

    a. Emergency Services

        1) Immediately upon Enrollee presentation at the service delivery site, including non-network and out-of-area facilities; and

2) In accordance with 42 U.S.C. §1396u-2(b)(2) and 42 CFR 434.30, provide coverage for Emergency Services to Enrollees 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.

b. Primary Care

1) Within 48 hours of the Enrollee's request for Urgent Care;

2) Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

3) Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care, unless an appointment is required more quickly to assure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule in Appendix W of all MassHealth provider manuals, per 130 CMR 450.141.

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

d. Specialty Care

1) Within 48 hours of the Enrollee's request for Urgent Care;

2) Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

3) Within 60 calendar days for Non-Symptomatic Care.

e. For Enrollees newly placed in the care or custody of DCF

1) Within 7 calendar days of receiving a request from a DCF caseworker, a DCF Health Care Screening shall be offered at a reasonable time and place. Such DCF Health Care Screening shall attempt to detect life threatening conditions, communicable diseases, and/or serious injuries, or indication of physical or sexual abuse; and

2) Within 30 calendar days of receiving a request from a DCF caseworker, a comprehensive medical examination, including all age appropriate screenings according to the EPSDT Periodicity Schedule shall be offered at a reasonable time and place.

f. All Other Services - in accordance with usual and customary community standards.

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

2. Behavioral Health Services (as used in **Appendix C**)

   a. Emergency Services

      Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present at any qualified Provider, whether a Network Provider or a non-Network provider.

   b. ESP Services

      Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present for such services.

   c. Urgent Care

      Within 48 hours for services that are not Emergency Services or routine services.

   d. All Other Behavioral Health Services

      Within 14 calendar days.

   e. For services described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

      1) Non-24-Hour Diversionary Services – within two calendar days of discharge;

      2) Medication Management – within 14 calendar days of discharge;

      3) Other Outpatient Services – within seven calendar days of discharge; and

      4) Intensive Care Coordination Services – within the time frame directed by EOHHS.

3. 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 Members.

4. The Contractor may request an exception to the access standards set forth in this **Section 2.9.B** by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to, or better than, the usual and customary community standards for accessing care. Upon approval by EOHHS, the Contractor shall notify Enrollees in writing of such alternative access standards.

5. The Contractor shall have a system in place to monitor and document access and appointment scheduling standards. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/access standards specified above in **Section 2.9.B.1 and 2** and shall promptly address any access deficiencies, including but not limited to taking corrective action if there is a failure to comply by a Provider. Annually, in accordance

with **Appendix A**, the Contractor shall evaluate and report to EOHHS Network-wide compliance with the access standards specified in **Section 2.9.B.1 and 2**.

C. Availability

The Contractor shall execute and maintain written contracts with Providers to ensure that Enrollees have access to MCO Covered Services within a reasonable distance and travel time from the Enrollee's residence, as provided below. The Contractor shall take into account both walking and public transportation.

1. Primary Care Providers

a. The Contractor shall develop and maintain a network of Primary Care Providers (PCP network) that ensures PCP coverage and availability throughout the Regions 24 hours a day, seven days a week.

b. The Contractor shall maintain a sufficient number of PCPs, defined as one adult PCP for every 200 adult Enrollees and one pediatric PCP for every 200 pediatric Enrollees throughout the Regions, provided that, EOHHS may approve a waiver of the above ratios in accordance with federal law.

c. The PCP network shall include a sufficient number of PCPs to offer each Enrollee a choice of at least two appropriate PCPs with open panels. An appropriate PCP is defined as a PCP who:

1) Is located within;

a) 40 miles or 40 minutes travel time from the Enrollee's residences for Enrollees in the Oak Bluffs and Nantucket Service Areas listed in **Appendix R**

b) 15 miles or 30 minutes travel time from the Enrollee's residence for all other Enrollees;

2) Has qualifications and expertise commensurate with the health care needs of the Enrollee; and

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

d. If the Contractor does not meet this standard in any part of a Region, the Contractor shall demonstrate to EOHHS that it meets this standard when factoring in PCPs in a contiguous Region or Regions that are within 15 miles or 30 minutes travel time from the Enrollee's residence.

2. Physical Health Services

a. Acute inpatient services - within 20 miles or 40 minutes travel time from an Enrollee's residence, except for Martha's Vineyard and Nantucket Islands for the Contractor may meet the standard by including in its Provider Network any hospitals located on these islands that provide acute inpatient services or the closest hospital located off each island that provide acute inpatient services;

b. Rehabilitation hospital services - within 30 miles or 60 minutes travel time from an Enrollee's residence;

c. Urgent Care services - within 15 miles or 30 minutes travel time; and

d. Other Physical Health Services - in accordance with the usual and customary community standards for accessing care.

3. Specialists

a. The Contractor shall maintain an Obstetrician/Gynecologist-to-female Enrollee ratio of one to 500, throughout the Region, provided that, EOHHS may approve a waiver of the above ratio in accordance with federal law. Such ratio should include female Enrollees age 10 and older. When feasible, Enrollees shall have a choice of two Obstetrician/Gynecologists. The Contractor shall report to EOHHS annually in accordance with **Appendix A**, the following:

1) A specialist-to-Enrollee ratio report showing the number of each specialist by specialty type per the number of Enrollees;

2) As specified by EOHHS, a geographic access report for high volume specialty provider types based on utilization, demonstrating access by geography; and

b. For any part of the Region where the Contractor does not meet this standard, the Contractor must demonstrate to EOHHS that it meets this standard when factoring in Obstetricians/Gynecologists in a contiguous Region or Regions that are within 15 miles or 30 minutes travel time from the Enrollee's residence.

c. For all other specialist providers, the Contractor must demonstrate to EOHHS that these specialist providers are available within

1) 40 miles or 40 minutes travel time from the Enrollee's residences for Enrollees in the Oak Bluffs and Nantucket Service Areas; or

2) 20 miles or 40 minutes travel time from the Enrollee's residence for all other Enrollees.

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

The Contractor shall ensure that Enrollees have access to a choice of at least two Network Providers who provide Behavioral Health Services to the extent that qualified, willing Providers are available.

a. Behavioral Health Inpatient Services - within 60 miles or 60 minutes travel time from the Enrollee's residence;

b. ESP Services – in accordance with the geographic distribution set forth in **Appendix G, Exhibit 1**, as updated by EOHHS from time to time;

c. As directed by EOHHS, Community Service Agencies (Intensive Care Coordination providers) – in accordance with the geographic distribution provided by EOHHS; and

d. Behavioral Health Outpatient Services, for the specialties specified by EOHHS within 30 miles or 30 minutes travel time from the Enrollee's residence.

5. Pharmacy

a. The Contractor shall develop and maintain a network of retail pharmacies that ensure prescription drug coverage and availability throughout the Regions seven days a week.

b. The Contractor must demonstrate to EOHHS that at least one retail pharmacy is available within 15 miles or 30 minutes travel time from the Enrollee's residence.

6. The Contractor shall document and submit to EOHHS, in writing, a justification for any exceptions to the standards specified in **Section 2.9.C.** Such justification shall be based on the usual and customary community standards for accessing care. Usual and customary community standards shall be equal to or better than such access in the Primary Care Clinician Plan.

D. Access for Non-English Speaking Enrollees

The Contractor shall ensure that non-English speaking Enrollees have a choice of at least two PCPs, and at least two Behavioral Health Providers within each behavioral health covered service category, in the Prevalent Language in the Regions provided that such provider capacity exists throughout the Region.

E. Direct Access to Specialists

For Enrollees including, but not limited to, Enrollees with Special Health Care Needs, determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place 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.

F. Certification to EOHHS

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 CFR 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.

Section 2.10 Enrollee Services

The Contractor shall:

A. Written Materials

Unless otherwise provided in this Contract, ensure that all written materials provided by the Contractor to Enrollees and Members are:

1. Are Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor's membership;
2. Are produced in a manner, format, and language that may be easily understood by persons with limited English proficiency;
3. Are translated into Prevalent Languages of the Contractor's membership;
4. Are made available in Alternative Formats upon request free-of-charge, including video and audio; and information is provided about how to access written materials in those formats and about the availability of free auxiliary aids and services, including, at a minimum, services for Enrollees with disabilities; and
5. Are mailed with a language card that indicates that the enclosed materials are important and should be translated immediately, and that provides information on how the Enrollee may obtain help with getting the materials translated;
6. Use a font size no smaller than 12 point; and
7. Include a large print tagline (i.e., no smaller than 18 point font size);

B. Electronic Information

Not provide Enrollee information required by this Contract electronically unless all of the following are met:

1. The format is readily accessible;
2. The information is placed in a location on the Contractor's web site that is prominent and readily accessible;
3. The information is provided in an electronic form which can be electronically retained and printed;
4. The information is consistent with the content and language requirements of this Contract; and

5. The Enrollee is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days.

C. Information Required

1. Provide Enrollee Information to Enrollees and, upon request, to Members, including all the items detailed in **Section 2.4.B.2.f**. The Contractor shall clearly identify differences in such information as it applies to the different Coverage Types which may be achieved by providing different Enrollee Information for Enrollees based on Coverage Types, or by providing separate inserts for the different populations. The Contractor shall make available written translations of Enrollee Information in Prevalent Languages and inform Enrollees how to obtain translated Enrollee Information or how to obtain an oral translation in a language other than a Prevalent Language. The Contractor shall make available Enrollee Information in Alternative Formats and inform Enrollees how to obtain such Enrollee Information;

2. Provide Enrollee Information as follows:

   a. Mail a printed copy of the information to the Enrollee's mailing address;

   b. Provide the information by email after obtaining the Enrollee's agreement to receive information by email;

   c. Post the information on the Contractor's website and advise the Enrollees in paper or electronic form that the information is available on the Internet and include the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided free auxiliary aids and services upon request; or

   d. Provide the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

3. As further specified by EOHHS, the Contractor shall provide and maintain its Enrollee handbook, Provider directory, and its drug formulary on its website in a reasonably easy to find location.

D. Handbooks

As directed by EOHHS, update and distribute, in the normal course of business, Enrollee handbooks including the MCO Covered Services list. As further directed by EOHHS, such Enrollee handbooks shall conform to a model provided by EOHHS;

E. Education Material

Update Enrollee and Provider education materials that are provided to individuals under age 21, or Providers of services to individuals under age 21, and update and distribute such materials to describe EPSDT and CBHI services as further directed by EOHHS;

F. Enrollee Services Department

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;

G. Enrollee Services Department Standards

Maintain employment standards and requirements (e.g. education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff for the Enrollee services department;

H. Enrollee Services Department Staff

Ensure that Enrollee services department staff have access to:

1. The Contractor's Enrollee database;
2. The Eligibility Verification System (EVS); and
3. An electronic Provider directory that includes, but is not limited to, the information specified in **Section 2.7.E** of this Contract;

I. Enrollee Services Telephone Line

Operate a toll-free Enrollee services telephone line a minimum of nine hours per day during normal business hours, Monday through Friday, which shall:

1. Have at least 90% of calls answered by a trained customer service department representative (non-recorded voice), within 30 seconds or less as reported in accordance with **Appendix A**;
2. Have less than a 5% abandoned call rate;
3. Make oral interpretation services available free-of-charge to Members and Enrollees in all non-English languages spoken by Members and Enrollees; and;
4. Maintain the availability of services free-of-charge, such as TTY services or comparable services for the deaf and hard of hearing;

J. Information for Enrollees and Potential Enrollees

Ensure that customer service department representatives shall, upon request, make available to Enrollees and Potential Enrollees in the Contractor's Plan information concerning the following:

1. The identity, locations, qualifications, and availability of Providers;
2. The rights and responsibilities of Enrollees including, but not limited to, those Enrollee rights described in **Section 5.1.L**;

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 as explained in the Enrollee handbook;

4. How Enrollees and Potential Enrollees may access oral interpretation services free-of-charge in any non-English language spoken by Enrollees and Potential Enrollees;

5. How Enrollees and Potential Enrollees may access written materials in Prevalent Languages and Alternative Formats;

6. All MCO Covered Services and Non-MCO Covered Services that are available to Enrollees either directly or through referral or authorization; and

7. Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of the Plan.

K. Miscellaneous Customer Service Requirements

Ensure that it customer services representatives who are assigned to:

1. Respond to MassHealth specific Inquiries:

   a. Understand and have a working knowledge of the Contract between EOHHS and the Contractor;

   b. Answer Enrollee Inquiries, including those related to enrollment status and accessing care;

   c. Are trained in Grievance, Internal Appeals, and BOH Appeals processes and procedures, as specified in **Section 2.12**;

   d. Refer Enrollee Inquiries that are of a clinical nature, but non-behavioral health, to clinical staff with the appropriate clinical expertise to adequately respond;

   e. 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, examples of administrative Inquiries shall include requests for general information regarding particular BH 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 BH clinical professional to provide an adequate response; and

   f. Have the ability to answer Enrollee Inquiries in the Enrollee's primary language free-of-charge through an alternative language device or interpreter;

2. Respond to questions from Providers are informed about the requirements and process for applicable Providers to become trained and certified in administering the CANS Tool and can respond to questions from Providers about these requirements and processes. The Contractor

shall provide training to its newly-hired and current customer service representatives about who, when, where and how Providers must be CANS trained and certified and provide refresher trainings as directed by EOHHS or as the Contractor determines is necessary; and

3. Respond to Enrollee inquiries are informed about the CANS and can respond to questions from Enrollees about the CANS. The Contractor shall provide training to its newly-hired and current customer service representatives about the CANS and how it is generally used in Behavioral Health Clinical Assessments and as part of the Discharge Planning process from Inpatient Mental Health Services and Community Based Acute Treatment Services;

L. Customer Service Training

Establish a schedule of intensive training for newly-hired and current customer service representatives about:

1. When, where and how Enrollees may obtain EPSDT screenings, diagnosis and treatment services; and

2. The CBHI and when those services are available. Such trainings shall include the following and any other activities that are directed by EOHHS:

   a. A written curriculum, which shall be prior-approved by EOHHS and subject to modification in whole or in part at the discretion of EOHHS; and

   b. Refresher trainings that are provided as directed by EOHHS, or as the Contractor determines necessary, to assure that Enrollees receive accurate information about EPSDT and the CBHI;

M. My Account Page Application

With Enrollee consent, assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page Application on the Virtual Gateway, as follows:

1. If the Contractor learns from an Enrollee or an Authorized Representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the Contractor obtains demographic information from the Enrollee or Authorized Representative, the Contractor shall provide such information to EOHHS by entering it into the Change Form via the My Account Page Application on the Virtual Gateway, after obtaining the Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

2. Prior to entering such demographic information, the Contractor shall advise the Enrollee as follows: "Thank you for this change of address [phone] information. You are required to provide updated address [phone] information to MassHealth. We would like to help you to do that so, with your oral permission, we will forward this information to MassHealth. You may also provide MassHealth with information about your race or ethnicity. This is not required,

but it will help MassHealth to improve Member services. You have provided us with this information. If you do not object, we will pass that information on to MassHealth for you."

3. If the Contractor receives updated demographic information from a third party, such as a Provider, a vendor hired to obtain demographic information, or through the post office, the Contractor must confirm the new demographic information with the Enrollee, and obtain the Enrollee's permission, prior to submitting the information to EOHHS on the Change Form.

4. The Contractor shall ensure that all appropriate staff entering this information have submitted the documentation necessary to complete this function on the Virtual Gateway and completed any necessary Virtual Gateway training requirements.

N. Additional Information Requirement

Provide additional information that may be needed for Enrollees and Potential Enrollees to fully understand the requirements and benefits of the Contractor's Plan as directed by EOHHS;

O. Definitions

Adopt definitions as specified by EOHHS, consistent with 42 CFR 438.10(c)(4)(i).

P. Notice to Enrollees

As further directed by EOHHS, the Contractor's notices to Enrollees shall conform to models provided by EOHHS.

Section 2.11 Marketing Activity Requirements

A. General Requirements

In conducting any Marketing activities described herein, the Contractor shall:

1. Ensure that all Marketing Materials regarding the Contractor's Plan clearly state that information regarding all MassHealth Managed Care enrollment options including, but not limited to, the Contractor's Plan, are available from the MassHealth Customer Service Center. The Contractor shall ensure that all written Marketing Materials prominently display the telephone number and hours of operation of the MassHealth Customer Service Center in the same font size as the same information for the Contractor's customer service center. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by the Contractor;

2. Comply with all applicable information requirements set forth in 42 CFR 438.10 when conducting Marketing activities and preparing Marketing Materials;

3. Submit all Marketing Materials to EOHHS for approval prior to distribution. The Contractor shall submit Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible;

4. Comply with any requirement imposed by EOHHS pursuant to **Section 3.5** of this Contract;

5. Distribute and/or publish Marketing Materials throughout the Contractor's Regions, as indicated in **Appendix F**, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials (1) to a part of the Contractor's Regions outlined in **Appendix F**; or (2) where the campaign relates to a local event (such as a health fair) or to a single Provider (such as a hospital or clinic), to a certain zip code or zip codes; and

6. Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval.

B. Permissible Marketing Activities

The Contractor may engage in only the following Marketing activities, in accordance with the requirements stated in **Section 2.11.A** above.

1. A health fair or community activity sponsored by the Contractor provided that the Contractor shall notify all MassHealth-contracted MCO or Accountable Care Partnership 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 MCOs or Accountable Care Partnership 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 MCOs and Accountable Care Partnership Plans. The Contractor may conduct or participate in Marketing at Contractor or non-Contractor sponsored health fairs and other community activities only if:

    a. Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

    b. Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the Contractor's Plan.

2. The Contractor may participate in Health Benefit Fairs sponsored by EOHHS. Such Health Benefit Fairs will be held in accordance with **Section 3.4**.

3. The Contractor may market the Contractor's Plan to Members in accordance with **Section 2.11.A** above, by distributing and/or publishing Marketing Materials throughout the Contractor's Regions, as indicated in **Appendix F** or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

    a. Posting written Marketing Materials that have been pre-approved by EOHHS at Provider sites and other locations; and posting written promotional Marketing Materials at Network Provider and other sites throughout the Contractor's Regions;

b. Initiating mailing campaigns that have been pre-approved by EOHHS, where the Contractor distributes Marketing Materials by mail; and

c. Television, radio, newspaper, website postings, and other audio or visual advertising.

C. Prohibitions on Marketing and Enrollment Activities

The Contractor shall not:

1. Distribute any Marketing Material that has not been pre-approved by EOHHS;

2. Distribute any Marketing Material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the Marketing Material, including but not limited to, any assertion or statement, whether written or oral, that:

   a. The recipient of the Marketing Material must enroll in the Contractor's Plan in order to obtain benefits or in order to not lose benefits; or

   b. The Contractor is endorsed by CMS, the federal or state government or similar entity;

3. Seek to influence a Member's enrollment in the Contractor's Plan in conjunction with the sale or offering of any private or non-health insurance products (e.g., life insurance);

4. Seek to influence a Member's enrollment into the Contractor's Plan in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts;

5. Directly or indirectly, engage in door-to-door, telephonic, email, texting, or any other Cold-call Marketing activities;

6. Engage in any Marketing activities which could mislead, confuse or defraud Members or Enrollees, or misrepresent MassHealth, EOHHS, the Contractor or CMS;

7. Conduct any Provider site Marketing, except as provided in **Sections 2.11.A.4 and 2.11.B.3.a**;

8. Incorporate any costs associated with Marketing or Marketing incentives, or Non-Medical Programs or Services in the report specified in **Appendix A**; or Engage in Marketing activities which target Members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

D. Marketing Plan and Schedules

1. The Contractor shall make available to EOHHS, upon request, for review and approval:

   a. A comprehensive Marketing Plan including proposed Marketing approaches to groups and individuals in the Contractor's Regions; and

b. Current schedules of all Marketing activities, including the methods, modes, and media through which Marketing Materials will be distributed.

2. As requested by EOHHS, the Contractor shall present its Marketing Plan in person to EOHHS for review and approval.

3. As requested by EOHHS, the Contractor shall submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its Marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud Members or the state.

E. Information to Enrollees

Nothing herein shall be deemed to prohibit the Contractor from providing non-Marketing information to Enrollees consistent with this Contract, regarding new services, personnel, Enrollee education materials, Care Management programs and Provider sites.

F. MassHealth Benefit Request and Eligibility Redetermination Assistance

As directed by EOHHS, the Contractor or Provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:

1. Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants;

2. Assist MassHealth applicants in completing and submitting MBRs;

3. Offer to assist Enrollees with completion of the annual ERV form; and

4. Refer MassHealth applicants to the MassHealth Customer Service Center.

Section 2.12 Inquiries, Ombudsman Services, Grievances, Internal Appeals and BOH Appeals

A. General Requirements

The Contractor shall:

1. Maintain written policies and procedures for:

a. The receipt and timely resolution of Grievances and Internal Appeals, as further described in **Section 2.12.B** below. Such policies and procedures shall be approved by EOHHS; and

b. The receipt and timely resolution of Inquiries, where timely resolution means responding to the Inquiry at the time it is raised to the extent possible or, if not possible, acknowledging the Inquiry within 1 business day and making best efforts to resolve the Inquiry within 1 business day of the initial Inquiry. Such policies and procedures shall be approved by EOHHS;

2. Review the Inquiry, Grievance and Internal Appeals policies and procedures established pursuant to **Section 2.12.A.1** above, at least annually to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS;

3. Create and maintain records of Inquiries, Grievances, Internal Appeals, and BOH Appeals, using the health information system(s) specified in **Section 2.14.E**, to document:

    a. The type and nature of each Inquiry, Grievance, Internal Appeal, and BOH Appeal;

    b. How the Contractor disposed of or resolved each Grievance, Internal Appeal, or BOH Appeal; and

    c. What, if any, corrective action the Contractor took;

4. Report to EOHHS regarding Inquiries, Grievances, Internal Appeals and BOH Appeals, as described in **Appendix A** and as follows in a form and format specified by EOHHS:

    a. Annually report a summary

    b. Monthly report

        1) Number of Appeals per 1,000 Enrollees;

        2) Number of Grievances per 1,000 Enrollees;

5. Assure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any Inquiry, Grievance, Internal Appeal, or BOH Appeal;

6. Provide Enrollees with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes, as specified in **Section 2.4.B.2.f.20**; and

7. Provide the information specified in **Section 2.4.B.2.f.21** to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor.

8. In addition to other obligations set forth in this Contract related to Ombudsman Services, the Contractor shall support Enrollee access to, and work with, the Ombudsman to address Enrollee and Potential Enrollee requests for information, issues, or concerns related to the MassHealth MCO Program, by:

    a. Providing Enrollees with education and information about the availability of Ombudsman services including, when Enrollees contact the Contractor with a requests for information, issues, concerns, complaints, Grievances, Internal Appeals or BOH Appeals; and

b. Communicating and cooperating with Ombudsman staff as needed for such staff to address Enrollee or Potential Enrollee requests for information, issues, or concerns related to the Contractor, including:

1) Providing Ombudsman staff, with the Enrollee's appropriate permission, with access to records related to the Enrollee; and

2) Engaging in ongoing communication and cooperation with Ombudsman staff until the Enrollee's or Potential Enrollee's request or concern is addressed or resolved, as appropriate, including but not limited to providing updates on progress made towards resolution.

B. Grievances and Internal Appeals

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 Grievances and Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR Part 438, Subpart F. (For purposes of this Section, in cases where a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment, or may appoint an Appeal Representative to represent them, without parental/guardian consent.)

1. General Requirements

a. The Contractor shall put in place a standardized process that includes:

1) A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;

2) A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 2.12.B.2.a.3 and 2.12.B.4** below; and

3) A means for expedited resolution of Internal Appeals, as further specified in **Section 2.12.B.4.d**, 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 2.12.B.4.a**, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

b. The Contractor shall put in a place a mechanism to:

1) Accept Grievances filed either orally or in writing; and

2) Accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.12.B.2**, 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.

c. 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.

d. The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.12.B.2.**

2. Notice of Adverse Action

a. The Contractor shall put in place a mechanism for providing written notice to Enrollees of any Adverse Action in a form approved by EOHHS as follows.

1) The notice must meet the language and format requirements specified in **Section 2.10.A**.

2) The notice must explain the following:

a) The Adverse Action the Contractor has taken or intends to take;

b) The reason(s) for the Adverse Action, including the right of the 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;

c) The Enrollee's right to file an Internal Appeal 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;

d) The procedures for an Enrollee to exercise his/her right to file an Internal Appeal;

e) The circumstances under which expedited resolution of an Internal Appeal is available and how to request it;

f) That the Contractor will provide the 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;

g) That the Contractor will 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 he or she does not want to receive Continuing Services.

3) The notice must be mailed within the following timeframes:

a) For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action in accordance with 42 CFR 431.211, except as provided in 42 CFR 431.213. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to 5 calendar days before the Date of Action if the Contractor has facts indicating that action should be taken because of probable fraud by the Enrollee and the facts have been verified, if possible through secondary sources.

b) For denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials of payment where coverage of the requested service is not at issue, which include, but are not limited to, denials for the following reasons:

(i) Failure to follow prior authorization procedures;

(ii) Failure to follow referral rules; and

(iii) Failure to file a timely claim.

c) For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.6.C.5.a**, 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. Such extension shall be implemented as follows:

(i) The extension shall only be allowed if:

(a) The Provider, Enrollee or Appeal Representative requests the extension, or

(b) The Contractor can justify (to EOHHS, upon request) that:

(1) The extension is in the Enrollee's interest; and

(2) There is a need for additional information where:

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

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

(ii) If the Contractor extends the timeframe, it must:

(a) Give the Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

(b) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

d) For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.6.C.5.b.,** as expeditiously as the Enrollee's health requires but no later than 3 business days after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

(i) The extension shall only be allowed if:

(a) The Provider, Enrollee or Appeal Representative requests the extension, or

(b) The Contractor can justify (to EOHHS, upon request):

(1) The extension is in the Enrollee's interest; and

(2) There is a need for additional information where:

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

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

(ii) If the Contractor extends the timeframe, it must do the following:

(a) Give the Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

(b) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

e) For standard or expedited service authorization decisions not reached within the timeframes specified in **Sections 2.6.C.5.a. and b**., whichever is applicable, on the day that such timeframes expire.

f) When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 2.9.B**., within one business day upon notification by the Enrollee or Provider that one of the access standards in **Section 2.9.B**. was not met.

3. Handling of Grievances and Internal Appeals

In handling Grievances and Internal Appeals, the Contractor shall:

a. Inform Enrollees of the Grievance, Internal Appeal, and BOH Appeal procedures, as specified in **Section 2.4.B.2.f.20**.

b. Give reasonable assistance to Enrollees in completing forms and following procedures applicable to Grievances and Internal Appeals, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TTD and interpreter capability;

c. Provide notice of Adverse Actions as specified in **Section 2.12.B.2**;

d. Accept Grievances and Internal Appeals filed in accordance with **Section 2.12.B.1.b**;

e. Send written acknowledgement of the receipt of each Grievance or Internal Appeal to the Enrollee and Appeal Representative within one business day of receipt by the Contractor;

f. Ensure that the individuals who make decisions on Grievances and Internal Appeals:

1) Are individuals who were not involved in any previous level of review or decision-making, and are not the subordinates of any such individuals; and

2) Take into account all comments, documents, records, and other information submitted by the Enrollee or the Appeal Representative without regard to whether such information was submitted or considered in the Adverse Action determination.

g. Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

1) An appeal of a denial that is based on lack of medical necessity;

2) Grievances regarding the denial of an Enrollee's request that an Internal Appeal be expedited, as specified in **Section 2.12.B.4.d.3**; and

3) Grievances regarding clinical issues;

h. Ensure that the following special requirements are applied to Internal Appeals:

1) The Contractor shall offer one level of review of an Adverse Action for Internal Appeals;

2) All reviews of Internal Appeals shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action;

3) The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and shall not require the Enrollee or an Appeal Representative to confirm such oral requests in writing as specified in **Section 2.12.B.1.b.2**;

4) The Contractor shall provide a reasonable opportunity for the Enrollee or an Appeal Representative to present evidence and allegations of fact or law, in person as well as in writing, and shall inform the Enrollee or an Appeal Representative about the limited time available for this opportunity in the case of expedited Internal Appeals;

5) The Contractor shall provide the Enrollee and an Appeal Representative, before and during the Internal Appeals process, the Enrollee's case file, including medical records, and any other documentation and records considered, relied upon, or generated during the Internal Appeals process. This information shall be provided free of charge and sufficiently in advance of the applicable resolution timeframe; and

6) The Contractor shall include, as parties to the Internal Appeal, the Enrollee and Appeal Representative or the legal representative of a deceased Enrollee's estate;

4. Resolution and Notification of Grievances and Internal Appeals

a. The Contractor shall:

1) Dispose of each Grievance, resolve each Internal Appeal, and provide notice of each disposition and resolution, as expeditiously as the Enrollee's health condition requires, within the following timeframes:

2) For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Enrollee or the Enrollee's Authorized Appeal Representative, unless this timeframe is extended in accordance with **Section 2.12.B.4.b**;

3) For standard resolution of Internal Appeals and notice to the affected parties, no more than 30 calendar days from the date the Contractor received either in writing or orally, whichever comes first, the Enrollee request for an Internal Appeal unless this timeframe is extended under **Section 2.12.B.4.b**. and

4) For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours from the date the Contractor received the expedited Internal Appeal unless this timeframe is extended under **Section 2.12.B.4.b**. The Contractor shall process the expedited Internal Appeal even if a Provider is allegedly serving as the Enrollee's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form. The Contractor must require that the Provider submit a signed Authorized Appeal Representative form to the Contractor as documentation that the Enrollee did in fact authorize the Provider to file the expedited Internal Appeal on the Enrollee's behalf, as long as the expedited Internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

b. Extend the timeframe in **Section 2.12.B.4.a.1-3** by up to 14 calendar days if:

1) The Enrollee or Appeal Representative requests the extension, or

2) The Contractor can justify (to EOHHS upon request) that:

a) The extension is in the Enrollee's interest; and

b) There is a need for additional information where:

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

(ii) Such outstanding information is reasonably expected to be received within 14 calendar days;

3) For any extension not requested by the Enrollee, the Contractor shall:

a) Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the delay;

b) 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 and the Enrollee's right to file a grievance; and

c) Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date of extension expires.

c. Provide notice in accordance with **Section 2.12.B.4.a** regarding the disposition of a Grievance or the resolution of a standard Internal Appeal or an expedited Internal Appeal as follows:

1) All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10. For notices of an expedited Internal Appeal resolution, the Contractor must also make reasonable efforts to provide oral notice to the Enrollee; and

2) The notice shall contain, at a minimum, the following:

a) The results of the resolution process and the effective date of the Internal Appeal decision;

b) For Internal Appeals not resolved wholly in favor of the Enrollee:

(i) The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing Form; and

(ii) That the Enrollee will receive Continuing Services, if applicable, while the BOH Appeal is pending if the Enrollee submits the appeal request to the BOH within 10 days of the Adverse Action, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services; and

d. Resolve expedited Internal Appeals as follows:

1) The Contractor shall resolve Internal Appeals expeditiously in accordance with the timeframe specified in **Section 2.12.B.4.a.3** when the Contractor determines (with respect to an Enrollee's request for expedited resolution) or a Provider indicates (in making the request for expedited resolution on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall process the expedited Internal Appeal even if the Provider is allegedly serving

as the Enrollee's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form.

2) The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support an Enrollee's Internal Appeal.

3) If the Contractor denies an Enrollee's request for an expedited resolution of an Internal Appeal, the Contractor shall:

a) Transfer the Internal Appeal to the timeframe for standard resolution in **Section 2.12.B.4.a.2** above;

b) Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the denial, and follow-up within two calendar days with a written notice. Such notice shall include the Enrollee's right to file a Grievance; and

c) Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the applicable deadlines set forth in this Contract.

4) The Contractor shall not deny a Provider's request (on an Enrollee's behalf) that an Internal Appeal be expedited unless the Contractor determines that the Provider's request is unrelated to the Enrollee's health condition.

C. Board of Hearings

The Contractor shall:

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:

a. The Contractor has issued a decision following its review of the Adverse Action; or

b. The Contractor fails to act within the timeframes for reviewing Internal Appeals or fail to satisfy applicable notice requirements.

2. Include with any notice following the resolution of a standard Internal Appeal or an expedited Internal Appeal, as specified in **Section 2.12.B.4.c**, 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

3. Notify Enrollees that:

a. Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services; and

b. 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 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.

4. Be a party to the BOH Appeal, along with the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

D. Additional Requirements

The Contractor shall:

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. For decisions involving Behavioral Health Services, EOHHS may consult with the Deputy Commissioner of the Department of Mental Health in its review of the Contractor's decision;

2. Upon learning of a hearing scheduled on a BOH Appeal concerning such 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;

3. Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;

4. Submit all applicable documentation to the BOH, EOHHS, the 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;

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;

6. Comply with and implement the decisions of the BOH;

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

8. Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:

    a. Determine whether each Enrollee who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 2.12.C.1**;

    b. If requested by the Enrollee, assist the Enrollee with completing a request for a BOH Appeal;

    c. 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;

    d. 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 he or she does not want to receive Continuing Service;

    e. 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;

    f. Ensure that the case folder and/or pertinent data screens are physically present at each hearing;

    g. Ensure that appropriate Contractor staff attend BOH hearings;

    h. Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;

    i. Upon notification by BOH of a decision, notify EOHHS immediately;

    j. Ensure that the Contractor implements BOH decisions upon receipt;

    k. Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;

    l. Coordinate with the BOH, as directed by EOHHS; and

    m. Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.

9. Provide information about the Contractor's grievances and appeals policies to all Providers and Material Subcontractors at the time the Contractor and these entities enter into a contract; and

10. Maintain records of Grievances and Appeals in a manner accessible to EOHHS, available to CMS upon request, and that contain, at a minimum, the following information:

    a. A general description of the reason for the Appeal or Grievance;

    b. The date received, the date of each review, and, if applicable, the date of each review meeting;

    c. Resolution of the Appeal or Grievance, and date of resolution; and

    d. Name of the Enrollee for whom the Appeal or Grievance was filed.

E. Continuing Services

The Contractor shall:

1. Comply with the provisions of 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service;

2. Provide Continuing Services until one of the following occurs:

    a. The Enrollee withdraws the Internal Appeal or BOH Appeal; or

    b. The BOH issues a decision adverse to the Enrollee;

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; and

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.

Section 2.13 Quality Management and Quality Improvement

A. Quality Management (QM) and Quality Improvement (QI) Principles

The Contractor shall:

1. Deliver quality care that enables Enrollees to stay healthy, get better and, if necessary, manage a chronic illness or disability. Quality care refers to:

    a. Clinical quality of physical health care;

b. Clinical quality of behavioral health care focusing on recovery, resiliency and rehabilitation;

c. Access and availability of primary and specialty health care Providers and services;

d. Continuity and coordination of care across settings, and transitions in care; and

e. Enrollee experience with respect to clinical quality, access and availability and Cultural and Linguistic Competence of health care and services, and continuity and coordination of care;

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:

a. Quantitative and qualitative data collection and data-driven decision-making;

b. 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;

c. Feedback provided by Enrollees and Providers in the design, planning, and implementation of its CQI activities; and

d. Issues identified by the Contractor or EOHHS; and

3. Ensure that the QM/QI requirements of this Contract are applied to the delivery of both Physical Health Services and Behavioral Health Services.

B. QM/QI Program Structure

The Contractor shall maintain a well-defined QM/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 QM/QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QM/QI organizational and program structure shall comply with all applicable provisions of 42 CFR Part 438, including Subparts D and E, Quality Assessment and Performance Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

The Contractor shall:

1. Establish a set of QM/QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QM/QI initiatives and for the completion of QM/QI initiatives in a competent and timely manner;

2. Ensure that such QM/QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

3. Establish internal processes to ensure that the QM activities for Physical and Behavioral Health Services reflect utilization across the Network and include all of the activities in this **Section 2.13** of this Contract and, in addition, the following elements:

    a. A process to utilize HEDIS results in designing QM/QI activities;

    b. A medical record review process for monitoring Network Provider 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;

    c. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the Contractor's Plan. The Contractor shall submit a survey plan to EOHHS for approval and shall submit the results of the survey to EOHHS;

    d. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

    e. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in Enrollee and family advisory councils;

    f. In collaboration with and as further directed by EOHHS, a plan to monitor Intensive Care Coordination and Family Training and Support Services according to fidelity measures that are consistent with national Wraparound standards;

    g. In collaboration with and as further directed by EOHHS, develop a process to monitor the quality of services using tools such as the MA DRM (Document Review Measure), or another tool approved by EOHHS, to evaluate the adequacy of medical record keeping for both Intensive Care Coordination and In-Home Therapy Services. The Contractor shall apply the approved quality-assessing tool at least annually on a mix of Intensive Care Coordination and In-Home Therapy Services provided across all of the Contractor's Regions. Unless otherwise directed by EOHHS, the Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Contractor's Enrollees who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 10 Enrollees' medical files per Region per Contract Year; and

    h. Outpatient Behavioral Health Services Monitoring

In collaboration with and as further directed by EOHHS, the Contractor shall develop a process to monitor the quality of services and evaluate the adequacy of medical record keeping for outpatient Behavioral Health services provided to Enrollees under the age of 21 in accordance with Appendix C, Exhibit 3. The Contractor shall utilize a quality assessment tool approved by EOHHS to conduct this review. Annually, the Contractor shall evaluate at least 10% of the Enrollees under the age of 21 who have received outpatient Behavioral Health services during each Contract Year, consisting of a mix of outpatient Behavioral Health providers, provided however that the Contractor shall not be required to review more than 10 Enrollees' medical files, or another number approved by EOHHS, per Region per Contract Year

4. Have in place a written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor's QM/QI initiatives. Such description shall:

    a. Address all aspects of health care, including specific reference to behavioral health care, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health aspects of the QM/QI program may be included in the QM/QI description, or in a separate QM/QI Plan referenced in the QM/QI description;

    b. Address the roles of the designated physician(s) and behavioral health clinician(s) with respect to QM/QI program;

    c. Identify the resources dedicated to the QM/QI program, including staff, or data sources, and analytic programs or IT systems; and

    d. 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;

5. Submit to EOHHS an annual QM/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.:

    a. Planned clinical and non-clinical initiatives;

    b. The objectives for planned clinical and non-clinical initiatives;

    c. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

    d. The individual(s) responsible for each clinical and non-clinical initiative;

    e. Any issues identified by the Contractor, EOHHS, Enrollees, and Providers, and how those issues are tracked and resolved over time; and

f. The evaluations of clinical and non-clinical initiatives, including Provider profiling activities as described in **Section 2.8.I** and the results of Network Provider satisfaction surveys as described in **Section 2.13.B.3.c**. above;

6. Evaluate the results QM/QI initiatives at least annually, and submit the results of the evaluation to the EOHHS QM manager. The evaluation of the QM/QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the clinical quality of physical and behavioral health care rendered, and accomplishments and compliance and/or deficiencies in meeting the previous year's QM/QI Strategic Work Plan; and

C. QM/QI Activities

1. Performance Measurement and Improvement Projects

The Contractor shall engage in performance measurement and 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 satisfaction. Measurement and improvement projects shall be conducted in accordance with 42 CFR 438.330, and at EOHHS's direction, and shall include, but are not limited to:

a. Performance Measurement

1) As further specified by EOHHS, the Contractor shall report the results of, or submit to EOHHS data 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).

2) EOHHS may, at its discretion and at any time, identify certain thresholds for Performance Measures which the Contractor must meet, and the Contractor shall work with EOHHS on such thresholds upon EOHHS request. If EOHHS is concerned with the Contractor's performance on such measures, the Contractor shall discuss such performance with EOHSS, and as further specified by EOHHS:

a) Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports; and

b) Provide EOHHS with, and implement as approved by EOHHS a concrete plan for improving its performance;

3) The Contractor shall demonstrate how to utilize Performance Measure results in designing ongoing QM/QI initiatives.

b. Clinical Performance Topic Review (CPTR)

1) The Contractor shall contribute to all annual CPTR-related processes, as directed by EOHHS, as follows:

a) Contribute to EOHHS's process for selecting CPTR measures, as applicable;

b) In accordance with 42 CFR 438.330(c), collect (or assist EOHHS in collecting) and submit to EOHHS, or EOHHS's designee, in a timely manner, data for CPTR measures selected by EOHHS;

c) Contribute to EOHHS's data quality assurance processes including, but not limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS; and

d) Contribute to EOHHS processes culminating in the publication of an annual report by EOHHS regarding the individual and aggregate performance of MassHealth-contracted health plans and the PCC Plan with respect to selected CPTR measures.

2) The Contractor shall demonstrate how to utilize CPTR results in designing QM/QI initiatives.

c. Member Surveys

1) The Contractor shall contribute to and participate in all EOHHS member satisfaction survey (MSS) activities, as directed by EOHHS, as follows:

a) In accordance with 42 CFR 438.330(c), collect (or assist EOHHS in collecting) and submit to EOHHS, or EOHHS's designee, in a timely manner, MSS member samples;

b) Contribute, as directed by EOHHS, 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; and

c) Contribute, as directed by EOHHS, to processes culminating in the publication of an annual report by EOHHS regarding the individual and aggregate MSS performance of MassHealth-contracted health plans and the PCC Plan.

2) The Contractor shall demonstrate best efforts to utilize MSS results in designing QM/QI initiatives.

3) The Contractor shall, starting in Contract Year 2 (i.e. 2019), administer and submit annually to EOHHS the results from the Health Plan Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) that the

Contractor submitted to NCQA as part of its accreditation process, including results of any supplemental questions as determined by EOHHS;

d. Quality Improvement Goals

The Contractor shall implement and adhere to all processes relating to the Quality Improvement Goals, as directed by EOHHS and as specified in **Appendix B**, as follows:

1) In accordance with 42 CFR 438.330, collect information and data in accordance with Quality Improvement Goal specifications for its Enrollees;

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 B;**

3) Evaluate the effectiveness of quality improvement interventions incorporating specified targets and measures for performance;

4) Plan and initiate processes to sustain achievements and continue improvements; and

5) Submit to EOHHS comprehensive written reports using the format, submission guidelines and frequency specified by EOHHS. 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 Goal cycle.

e. CMS-Specified Performance Measurement and Performance Improvement Projects

The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 CFR 438.330.

f. Assessments of Care Provided to Enrollees with Special Health Care Needs

The Contractor shall assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs, including but not limited to as described in **Section 2.5** of this Contract;

g. Assessments of care provided to Enrollees with LTSS needs.

2. External Quality Review (EQR) Activities

a. The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities, in accordance with 42 CFR 438.358. EQR Activities shall include, but are not limited to:

1) Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;

2) Annual validation of performance improvement projects required by EOHHS; and

3) At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees;

4) Annual validation of network adequacy during the preceding 12 months.

b. The Contractor shall take all steps necessary to support the EQRO in conducting EQR Activities including, but not limited to:

1) Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

a) Oversee and be accountable for compliance with all aspects of the EQR activity;

b) Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO and EOHHS staff in a timely manner;

c) Serve as the liaison to the EQRO and EOHHS and answer questions or coordinate responses to questions from the EQRO and EOHHS in a timely manner; and

d) 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) Maintaining data and other documentation necessary for completion of EQR Activities specified in **Section 2.13.C.2.a** above. The Contractor shall maintain such documentation for a minimum of seven years;

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;

4) Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;

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

6) Participating in any other activities deemed necessary by the EQRO and approved by EOHHS.

3. QM/QI for Utilization Management Activities

The Contractor shall utilize QM/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 the underutilization and overutilization of services. The QM/QI activities for the UM Program shall include:

a. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue medically necessary services;

b. At least one designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, and at least one designated Behavioral Health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, representative of the Contractor or subcontractor, with substantial involvement in the UM program; and

c. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QM/QI processes to support its UM program. Such document may be included in the QM/QI description, or in a separate document, and shall address how the UM program fits within the QM/QI structure, including how the Contractor collects UM information and uses it for QI activities.

4. Clinical Practice Guidelines

The Contractor shall:

a. Adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field or the Contractor's approved behavioral health performance specifications and Clinical Criteria;

2) Consider the needs of Enrollees;

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;

4) Prior to adoption, have been reviewed by the Contractor's Medical Director, as well as other of the Contractor's practitioners and Network Providers, as appropriate; and

5) Are reviewed and updated, as appropriate, or at least every two years:

a) 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 professionals; and

b) For guidelines that have been in effect two years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;

b. 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 Potential Enrollees. The Contractor shall make the clinical 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;

c. Establish explicit processes for monitoring the consistent application of clinical guidelines across Utilization Management decisions and other coverage of services decisions as permitted under this Contract, and Enrollee education decisions; and

d. Submit to EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

5. QM/QI Workgroups

As directed by EOHHS, the Contractor shall actively participate in QM/QI workgroups that are led by EOHHS, including the BHAC, attended by representatives of EOHHS, MassHealth-contracted health plans, and other entities, as appropriate, and that are designed to support QM/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.

6. Healthcare Plan Effectiveness Data and Information Set

The Contractor shall collect annual HEDIS data and contribute to all HEDIS related processes, as directed by EOHHS, and as follows:

a. Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports;

b. 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;

c. Upon request, submit to EOHHS Contractor-stratified rates for selected HEDIS measures specified by EOHHS.

d. Contribute to EOHHS's data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS;

e. Contribute to EOHHS processes culminating in the publication of any technical or other reports by EOHHS related to selected HEDIS measures.

D. EOHHS-Directed Performance Incentive Program

1. EOHHS may establish a Program of Performance Incentives. In order to receive any performance incentive payment, the Contractor shall comply with all EOHHS performance incentive requirements while maintaining satisfactory performance on all other contract requirements. The EOHHS Program of Performance Incentives may reward:

a. Improvement in Clinical Outcomes: Achievement of a certain pre-specified clinical goal;

b. Process Improvement: compliance with certain quality improvement processes or protocols; and

c. Participation in Quality Improvement Activities: simple participation in a designated quality improvement activity.

2. Provider Performance Incentives: The Contactor shall implement Provider Performance Incentives (or pay-for-performance), as directed by EOHHS and as appropriate, to promote compliance with guidelines and other QI initiatives, in accordance with **Section 5.1.H**. The Contractor shall:

a. Implement Provider Performance Incentives with best efforts to collaborate with Network Providers in development and revision of the incentives;

b. Take measures to monitor the effectiveness of such Provider Performance Incentives, and to revise incentives as appropriate, with consideration of Provider feedback;

c. Collaborate with EOHHS to design and implement Performance Incentives that are consistent with or complimentary to Performance Incentives established by the PCC Plan;

d. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Provider Performance Incentives; and

e. Ensure that all Provider Performance Incentives comply with all applicable state and federal laws.

E. Enrollee Incentives

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:

1. Take measures to monitor the effectiveness of such Enrollee Incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

2. Ensure that the nominal value of Enrollee Incentives do not exceed $30; and

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 all applicable state and federal laws.

F. Behavioral Health Services Outcomes

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. 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;

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:

    a. Recidivism;

    b. Adverse occurrences;

    c. Treatment drop-out;

    d. Length of time between admissions; and

    e. Treatment goals achieved.

G. External Research Projects

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:

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. 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

3. Submit to EOHHS, the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

H. External Audit/Accreditation Results

The Contractor shall:

1. Be accredited by the National Committee on Quality Assurance (NCQA) at the health plan (i.e. Managed Care Organization) level for the entire Medicaid population;

2. Annually, inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to EOHHS, at the direction of EOHHS, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any; and

3. Authorize NCQA to provide EOHHS a copy of its most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings; and expiration date of accreditation.

I. Health Information System

The Contractor shall maintain a health information system or systems consistent with the requirements set forth in **Section 2.14.E**. and 42 CFR 438.242 and that supports all aspects of the QM/QI Program.

Section 2.14 Data Management, Information Systems Requirements, and Reporting Requirements

A. General Requirements

1. The Contractor shall maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract, as described in this Section and as further directed by EOHHS;

2. Ensure a secure, HIPAA-compliant exchange of Member 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;

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 quickly and easily locate all relevant information, as specified by EOHHS. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal;

4. Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS; and

5. Actively participate in any EOHHS Systems Workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS, as further directed by EOHHS;

B. Encounter Data

The Contractor shall collect, manage, and report Encounter Data as described in this Section and as further specified by EOHHS. The Contractor shall:

1. Collect and maintain 100% Encounter Data for all MCO Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data;

2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;

3. Upon request by EOHHS, or its designee, provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;

4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include, but is not limited to, the data elements described in **Appendix E**, the delivering physician, and elements and level of detail determined necessary by EOHHS. As directed by EOHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the Servicing/Rendering, Referring, Prescribing and Primary Care Provider, and any National Drug Code (NDC) information on drug claims. As directed by EOHHS, such Encounter Data shall also include information related to denied claims and 340B Drug Rebate indicators;

5. Provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. The Contractor shall submit Encounter Data by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix E**;

6. Submit Encounter Data that is at a minimum compliant with the standards specified in **Appendix E**, including but not limited to standards for completeness and accuracy. To meet the completeness standard, all critical fields in the data must at a minimum contain valid values. To meet the accuracy standard, the Contractor must at a minimum have systems in

place to monitor and audit claims. The Contractor must also correct and resubmit denied encounters as necessary;

7. Ensure that all EPSDT screens, including behavioral health screenings, are explicitly identified in the Encounter Data in accordance with this **Section 2.14.B;**

8. Ensure that all initial Behavioral Health Clinical Assessments are explicitly identified in the Encounter Data submitted in accordance with this **Section 2.14.B;**

9. If EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not compliant with the benchmarks described in **Appendix E** the Contractor shall:

    a. Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

    b. Submit for EOHHS approval, within a time frame established by EOHHS which shall in no event exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

    c. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

    d. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is compliant with the standards described in **Appendix E**. The Contractor may be financially liable for such validation study;

10. Submit any correction/manual override file within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix E**.

11. Report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid; and

12. EOHHS may, at any time, modify the specifications required for submission of Encounter Data, including but not limited to requiring the Contractor to submit additional data fields to support the identification of Enrollees' affiliation with their Primary Care Provider.

13. At EOHHS' request, the Contractor shall submit denied claims, as further specified by EOHHS.

14. EOHHS may impose an intermediate sanction in accordance with **Section 5.3.K** in the event that Contractor's submitted Encounter Data does not meet the completeness, accuracy, timeliness, form, format, and other standards described in this Section;

15. At a time specified by EOHHS, the Contractor shall comply with all Encounter Data submission requirements related to HIPAA and the ASCX12N 837 format. This may include submitting

Encounter Data to include professional, institutional and dental claims and submitting pharmacy claims using NCPDP standards. This submission may require the Contractor to re-submit Encounter Data previously submitted to EOHHS in alternative formats.

C. Drug and Non-Drug Pharmacy Product Rebate Data

The Contractor shall collect, manage, and report Drug and Non-Drug Pharmacy Product Rebate Data as described in this Section and as further specified by EOHHS. The Contractor shall:

1. Collect and retain 100% of the Drug and Non-Drug Pharmacy Product Rebate Data in accordance with **Appendix A.** In addition, the Contractor shall:

    a. Ensure Drug and Non-Drug Pharmacy Product Rebate Data is consistent with MassHealth eligibility data;

    b. Create and maintain the file record layouts/schemas in accordance with EOHHS requirements for the purposes of capturing and submitting all drug and Non-Drug Pharmacy Product claims, whether pharmacy or physician-administered, 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;

    c. Submit Drug Rebate and Non-Drug Pharmacy Product Rebate Data files in accordance with the EOHHS-specified schedules for those submissions;

        1) The Contractor shall validate that all National Drug Codes (NDCs) submitted on physician- administered drugs for rebate match the Healthcare Common Procedure Coding System (HCPCS) being billed for, and include accurate NDC information (unit of measure and quantity);

        2) The Contractor shall instruct Providers to use the following indicators to identify 340B claims:

            a) For Physician-Administered Drugs add the identifier of “UD” to the HCPCS; and

            b) For Pharmacy-dispensed drugs attach Submission Clarification Code 20.

        3) The Contractor shall include 340B claims with the above indicators indicated in **Section 2.14.C.1.c.2** with the submission of Drug and Non-Drug Pharmacy Product Rebate Data files.

    d. In the event EOHHS or its designee is unable to accept certain Drug and Non-Drug Pharmacy Product 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;

e. Participate in workgroups, discussions, and meetings with EOHHS and its designees to support MassHealth rebate invoicing to drug manufacturers.

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 Drug and Non-Drug Pharmacy Product Rebate Data;

3. Produce Drug and Non-Drug Pharmacy Product Rebate Data according to the specifications, format, and mode of transfer reasonably developed by EOHHS or its designee;

4. Provide Drug and Non-Drug Pharmacy Product 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;

5. Submit Drug and Non-Drug Pharmacy Product 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;

6. Report as voided or reversed any claims in the Drug and Non-Drug Pharmacy Product Rebate Data submission that the Contractor includes in a file and then later determines should not have been included;

7. Ensure that the Drug Rebate and Non-Drug Pharmacy Product rebate contractual requirements are transferred completely and without interruption to the published MassHealth Drug Rebate and Non-Drug Pharmacy Product rebate file upload schedule whenever there is a change in the Drug Rebate operations and/or technical support staff; and

8. If EOHHS or the Contractor determines at any time that the Contractor's Drug Rebate and Non-Drug Pharmacy Product Data will not be or is not 100% on time and 99% complete:

   a. Notify EOHHS, five days prior to the Drug Rebate and Non-Drug Pharmacy Product Data scheduled submission date, that the Drug Rebate and Non-Drug Pharmacy Product Data will not be delivered on time or is not complete and provide an action plan and timeline for resolution;

   b. 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 and Non-Drug Pharmacy Product Data requirements, to implement improvements or enhancements to bring the timeliness and completeness to an acceptable level;

   c. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

   d. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Drug Rebate and Non-Drug Pharmacy Product Data is 100%

on time and 99% complete. The Contractor may be financially liable for such validation study.

D. Medical Records

The Contractor shall:

1. At a minimum, comply with, and require Network Providers to comply with, all statutory and regulatory requirements applicable to Enrollee medical records, including, but not limited to those contained in 130 CMR 433.409 and 450.205, and any amendments thereto. In addition, all Enrollee medical records, whether paper or electronic shall, at a minimum:

   a. Be maintained in a manner that is current, detailed, and organized and that permits effective patient care, utilization review and quality review;

   b. Include sufficient information to identify the Enrollee, date of encounter and pertinent information which documents the Enrollee's diagnosis;

   c. Describe the appropriateness of the treatment/services, the course and results of the treatment/services and treatment outcomes;

   d. Be consistent with current and nationally accepted professional standards for providing the treatment/services, as well as systems for accurately documenting the following:

      1) Enrollee information including, among other things, primary language spoken;

      2) Clinical information;

      3) Clinical assessments;

      4) Treatment plans;

      5) Treatment/services provided;

      6) Contacts with the Enrollee’s family, guardians, or significant others;

      7) Treatment goals and outcomes;

      8) All contacts with state agencies, as applicable; and

      9) Pharmacy records;

   e. Be consistent with commonly accepted standards for medical record documentation, as follows:

      1) Each page in the record contains the patient’s name or ID number;

2) Personal biographical data include the address, home telephone, mobile telephone, and work telephone numbers, name of employer, marital status, primary language spoken, and any disabilities, such as visually impaired, hearing impaired, uses a wheelchair;

3) All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials;

4) All entries are dated;

5) The record is legible to someone other than the writer;

6) Significant illnesses and medical conditions are indicated on the problem list;

7) Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record;

8) Past medical history is easily identified and includes serious accidents, operations and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations and childhood illnesses;

9) For children, adolescents and adults, there is appropriate notation concerning the use of cigarettes, alcohol and substances;

10) The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints;

11) Laboratory and other studies are ordered, as appropriate;

12) Working diagnoses are consistent with findings;

13) Treatment plans are consistent with diagnoses;

14) 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;

15) Unresolved problems from previous office visits are addressed in subsequent visits;

16) For children, adolescents and adults, there is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals;

17) If a consultation is requested, there is a note from the specialist in the record;

18) Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans;

19) There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure;

20) An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults); and

21) There is evidence that preventive screening and services are offered in accordance with the EPSDT Periodicity Schedule or, for individuals over age 21, the Provider's own practice guidelines, including the administration of behavioral health screenings in accordance **with Section 2.7.C.1.**

f. For records pertaining to inpatient hospital services, include the following information as set forth in 42 CFR 456.111:

1) Identification of the Enrollee;

2) The name of the Enrollee's physician;

3) Date of admission, and dates of application for and authorization of MassHealth benefits if application is made after admission;

4) The plan of care required under 42 CFR 456, et seq.;

5) Initial and subsequent continued stay review dates described under 42 CFR 456.128 and 456.133;

6) Date of operating room reservation, if possible;

7) Justification of emergency admission, if applicable;

8) Reason and plan for continued stay, if the attending physician believes continued stay is necessary; and

9) Other supporting material that the Contractor's Utilization Management staff, such as the staff described in **Section 2.6.D.1** of this Contract, believes appropriate to be included in the record.

g. For records pertaining to inpatient services in mental hospitals, include the following information as set forth in 42 CFR 456.211:

1) Identification of the Enrollee;

2) The name of the Enrollee's physician;

3) Date of admission, and dates of application for and authorization of MassHealth benefits if application is made after admission;

4) The plan of care required under 42 CFR 456.172 and 42 CFR 456.180;

5) Initial and subsequent continued stay review dates described under 42 CFR 456.233 and 456.234;

6) Reason and plan for continued stay, if the attending physician believes continued stay is necessary; and

7) Other supporting material that the Contractor's Utilization Management staff, such as the staff described in **Section 2.6.D.1**. of this Contract, believes appropriate to be included in the record.

2. Provide a copy of 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 as described in **Section 2.13**, including, but not limited to, EOHHS's annual External Quality Review and outcomes measurement studies performed by EOHHS. Medical record audits conducted by the Contractor at the request of EOHHS may be subject to validation performed directly by EOHHS or its agent.

   The Contractor shall 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.

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.

E. Health Information System (HIS) Requirements

The Contractor shall maintain a health information system (HIS) or Information Systems (together, the Contractor's Systems) as follows:

1. Such Systems shall enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract. The Contractor's Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following EOHHS standards:

a. The EOHHS Unified Process Methodology User Guide;

b. The User Experience and Style Guide Version 2.0;

c. Information Technology Architecture Version 2.0; and

d. Enterprise Web Accessibility Standards 2.0.

2. The HIS shall collect, analyze, integrate, and report data, including, but not limited to information regarding:

a. Utilization (including Non-MCO Covered Services);

b. Inquiries, Grievances, Internal Appeals, and BOH Appeals;

c. Disenrollments for reasons other than for loss of MassHealth eligibility;

d. Provider information in order to comply with **Section 2.10.H;**

e. Services furnished to Enrollees through an Encounter Data system, as specified in **Section 2.14.B**;

f. Enrollee characteristics, including but not limited to, race, ethnicity, spoken language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheel chair dependence, and characteristics gathered through such Plan contact with Enrollees, e.g., Care Needs Screenings administered upon enrollment, Care Management, or other reliable means;

g. Enrollee participation in Care Management programs by type of Care Management program, and identification of Enrollees as belonging to any of the special populations or subgroups identified in the definition of Enrollees with Special Health Care Needs;

3. The Contractor shall ensure that data received from Providers is 99% complete and 95% accurate by:

a. Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating on the basis of capitation payments;

b. Screening the data for completeness, logic and consistency; and

c. 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;

4. The Contractor shall make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(4);

5. Design Requirements

a. The Contractor shall 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.

b. The Contractor's Systems shall interface with EOHHS's Legacy MMIS system, EOHHS's MMIS system, the EOHHS Virtual Gateway, and other EOHHS IT architecture.

c. The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files, as specified in **Appendix J** of this Contract, include, but are not limited to:

1) Inbound Interfaces

a) Daily Inbound Demographic Change File;

b) HIPAA 834 History Request File;

c) Inbound Co-pay Data File (daily); and

d) Monthly Managed Care Provider Directory;

2) Outbound Interfaces

a) HIPAA 834 Outbound Daily File;

b) HIPAA 834 Outbound Full File;

c) HIPAA 834 History Response;

d) Fee-For-Service Wrap Services;

e) HIPAA 820; and

f) TPL Carrier Codes File;

d. The Contractor shall conform to HIPAA compliant standards for data management and information exchange;

e. The Contractor shall demonstrate controls to maintain information integrity;

f. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS; and

6. As set forth in 42 CFR 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act.

F. Claims Processing Requirements

1. The Contractor shall operate and maintain an industry standard HIPAA-compliant, on-line Claims processing system that includes but is not limited to the following characteristics:

   a. Supports HIPAA standard Inbound and Outbound Transactions, as defined by EOHSS:

      1) Health Care Claim Status Request and Response (276/277)

      2) Health Care Services Review – Request and Response (278)

      3) Health Care Claim Payment/Advice (835)

      4) Health Care Claim/Professional (837P)

      5) Health Care Claim/Institutional (837I)

      6) Health Care Eligibility Benefit Inquiry and Response (270/271)

      7) Functional Acknowledgement for Health Care Insurance (997)

      8) Implementation Acknowledgement for Health Care Insurance (999)

   b. Complies with all future updates to the HIPAA transactions and standards within the required timeframes;

   c. 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;

   d. Adjudicate Claims submitted in accordance with the timeframes specified in **Section 2.7.D.1**;

2. In addition, the Contractor shall:

   a. Implement timely filing initiatives to ensure that Claims are submitted within the allotted time restrictions set by the Contractor;

   b. 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

   c. 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. The Contractor shall report these edits to EOHHS as described in **Section 2.3.C**.

3. Claims Review

The Contractor shall:

a. 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;

b. 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;

c. Review suspended Claims for reasons why Claims were suspended, including reasons specified by EOHHS;

d. 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 2.14.A.2** and as further described by EOHHS.

e. 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.

4. Recoveries and Erroneous Payments

The Contractor shall notify EOHHS of recoveries and erroneous payments as described in **Section 2.3.C.3**.

G. Reports and Notification

1. General

a. The Contractor shall provide and require its Material Subcontractors and other subcontractors to provide, in accordance with the timelines, definitions, formats and instructions contained herein or as further specified by EOHHS:

1) All information required under this Contract, including but not limited to, the requirements of **Appendix A** or other information related to the performance of its or their responsibilities hereunder or under the subcontracts as reasonably requested by EOHHS;

2) Any information in its or their possession sufficient to permit EOHHS to comply with 42 CFR 138;

3) Any data from their clinical systems, authorization systems, claims systems, medical record reviews, network management visits, and Enrollee and family input;

4) Delivery of time sensitive data to EOHHS in accordance with EOHHS timelines; and

5) High quality, accurate data in the format and in the manner of delivery specified by EOHHS;

b. 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; and

c. Upon request, the Contractor shall provide EOHHS with the original data sets 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. Contract-Related Reports

Such reports shall include, but shall not be limited to, reports related to Contract performance, management and strategy.

a. The Contractor shall submit **Appendix A** reports in accordance with the timeframes and other requirements specified in **Appendix A**. For any report that indicates the Contractor is not meeting the targets set by EOHHS, the Contractor shall provide immediate notice explaining the corrective actions it is taking to improve performance. Such notice shall include root cause analysis of the problem the data indicates, the steps the Contractor has taken to improve performance, and the results of the steps taken to date. The Contractor may also include an executive summary to highlight key areas of high performance and improvement.

b. Failure to meet the reporting requirements in **Appendix A** shall be considered a breach of Contract.

3. Internal Management Reports

The Contractor shall submit to EOHHS, upon request, any internal reports that the Contractor uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/ loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance.

4. Additional Reports

a. In addition to the reports specifically required in **Appendix A**, the Contractor shall participate with EOHHS in the annual 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.

b. 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 the provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance. Further, the Contractor shall correct any errors in such reports in accordance with EOHHS guidelines.

c. Pursuant to 42 CFR 438.3(g), the Contractor shall comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS.

d. 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).

5. Other Ad-Hoc Reports

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.

6. Healthcare Plan Effectiveness Data and Information Set (HEDIS)

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. The Contractor must have its HEDIS results audited by an independent auditor in accordance with the National Committee for Quality Assurance (NCQA) guidelines. In developing such specifications, EOHHS shall consult with the Contractor and shall seek to be consistent with national HEDIS technical specifications where appropriate and reasonable for the MassHealth population as determined by EOHHS.

7. The Contractor shall provide to EOHHS all information necessary for EOHHS to perform an analysis of the Contractor's provision of managed care to Enrollees on measures and variables to be determined by EOHHS in consultation with the Contractor and consistent with HEDIS initiatives, where appropriate. Such measures and variables include, but are not limited to:

a. Prenatal care;

b. Pediatric well child care, including immunizations;

c. Pediatric asthma;

d. Diabetes; and

e. Behavioral Health Services.

8. Documentation

Upon EOHHS' request, the Contractor shall submit any and all documentation and materials pertaining to its performance under this Contract in a form and format designated by EOHHS. Such documentation shall include, but shall not be limited to the Contractor's:

a. Provider contracts;

b. Materials provided to Enrollees as set forth in this Contract;

c. Marketing plan and Marketing materials;

d. Grievance policies and procedures; and

e. Any other documentation and materials requested by EOHHS.

9. Additional Clinical Data

a. Upon request of EOHHS, the Contractor shall participate in the development of specifications for a data set on clinical data in the Contractor's Systems that include member identifier, and data on participation in the Children's Behavioral Health Initiative, Care Management programs and special populations; and

b. At the discretion of EOHHS, a data set developed on member enrollment in special programs and populations shall be produced and submitted to EOHHS in the frequency and format to be determined by EOHHS.

10. System Exchange of Encounter Data

a. The Contractor's Systems shall generate and transmit Encounter Data files according to the specifications outlined in **Appendix E** of this Contract, as updated from time-to-time:

b. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in **Section 2.14.B**; and

c. The Contractor shall participate in any Workgroup activities as specified in **Section 2.14.A**.

11. System Access Management and Information Accessibility Requirements

a. 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.

b. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

12. System Availability and Performance Requirements

a. The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers 24 hours a day, seven days a week.

b. 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.

c. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

13. Virtual Gateway

If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, the Contractor shall:

a. Submit all specified information including, but not limited to, invoices, Contract or other information to EOHHS through these web-based applications;

b. Comply with all applicable EOHHS policies and procedures related to such services;

c. Use all business services through the Virtual Gateway as required by EOHHS;

d. Take necessary steps to ensure that it, and its subcontractors or affiliates, has access to and utilize all required web-based services; and

e. 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.

14. Notification of Hospital Utilization

On a quarterly basis, the Contractor shall indicate in the appropriate **Appendix A** certification checklist 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 G M.G.L. c. 118E, § 13F.

H. Certification Requirements

In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive Officer or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit to EOHHS certification checklists in the form and format 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 his or her knowledge, information and belief, after reasonable inquiry, under the penalty of perjury:

1. Data on which payments to the Contractor are based;
2. All enrollment information, Encounter Data, and measurement data;
3. Data related to medical loss ratio requirements in aggregate for the Contractor's Enrollee population;
4. Data or information related to protection against the risk of insolvency; Documentation related to requirements around Availability and Accessibility of services, including adequacy of the Contractor's Provider Network;
5. Information on ownership and control, such as that pursuant to **Section 5.1.O**;
6. Reports related to overpayments; and
7. Data and other information required by EOHHS, including but not limited to, reports and data described in this Contract.

Section 2.15 Financial Stability Requirements

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

A. DOI Licensure

The Contractor shall be licensed as a Health Maintenance Organization by the Massachusetts Division of Insurance (DOI), pursuant to 211 CMR 43.

B. Cash Flow

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

C. Net Worth

The Contractor shall comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G

§ 25 (a) and 211 CMR 43:07(1) and continue to maintain an adjusted net worth in accordance with M.G.L. c 176G § 25(b) and 211 CMR 43:07(2).

D. Cash Reserves

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 Program Obligations." Funds from this restricted cash reserve may be dispersed only with prior written approval from EOHHS during the term of this Contract.

E. Working Capital Requirements

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:

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. EOHHS may take any action it deems appropriate, including termination of the Contract, if the Contractor:

    a. Does not maintain a positive working-capital balance; or

    b. Violates a corrective plan approved by EOHHS.

F. Insolvency Protection

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**.

G. Medical Loss Ratio (MLR) Requirements

1. Annually, and upon any retroactive change to the Base Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio (MLR) in accordance with 42 CFR 438.8. The Contractor shall perform such MLR calculation in aggregate for Contractor's Enrollee population and individually for each Rating Category. Within 212 days following the end of the Contract Year, the Contractor shall report such MLR calculations to EOHHS in a form and

format specified by EOHHS and as set forth in **Appendix A**. Such report shall include at least the following, pursuant to 42 CFR 438.8(k):

a. Total incurred claims

b. Expenditures on quality improving activities;

c. Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5),(7),(8), and (b);

d. Non-claims costs;

e. Premium revenue;

f. Taxes, licensing, and regulatory fees;

g. Methodology(ies) for allocation of expenses;

h. Any credibility adjustment applied;

i. Any remittance owed to the State, if applicable;

j. The calculated MLR;

k. A comparison of the information reported in this Section with the audited financial report required under this **Section 2.15**;

l. A description of the aggregation method used in calculating MLR;

m. The number of member months;

n. An attestation that the calculation of the MLR is accurate and in accordance with 42 CFR 438.8; and

o. Any other information required by EOHHS.

2. As further specified by EOHHS, the Contractor shall calculate its MLR in accordance with 42 CFR 438.8, as follows:

a. The numerator of the Contractor's MLR for each year is the sum of the Contractor's incurred medical claims and expenses, including medical sub-capitation arrangements, and fraud reduction activities.

b. The denominator of the Contractor's MLR for each year is the total Capitation Payment as described in **Appendix D**.

3. As further directed by EOHHS, the Contractor shall maintain a minimum MLR of 85 percent in 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 actual medical expenditures and the amount of medical expenditures that would have resulted in a MLR of 85%.

H. Auditing and Other Financial Requirements

The Contractor shall:

1. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits must comply with the following requirements and must be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards:

    a. 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) both;

        1) Specific to this Contract; and

        2) If directed by EOHHS, statements for the overall organization or consolidated statements that include other lines of business or other Medicaid products.

    b. The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS 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.

    c. 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. 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 on a quarterly basis in accordance with quarterly 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;

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 Board of the potential for insolvency;

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;

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

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.

I. Provider Risk Arrangements

To the extent permitted by law, the Contractor may enter into arrangements with Providers that place Providers at risk subject to the following limitations:

1. No incentive arrangement may include specific payments as an inducement to withhold, limit, or reduce services to Enrollees.

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 MCO Covered Services and quality. 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.

3. The Contractor must disclose these arrangements including all contracts, appendices and other documents describing these arrangements, to EOHHS as follows:

   a. As requested by EOHHS; or

   b. 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.

J. Right to Audit and Inspect Books

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

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

2. Services performed or the determination of amounts payable under the Contract;

3. Rates and payments made to Providers for each service provided to Enrollees; and

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)

K. Other Information

The Contractor shall provide EOHHS with any other information that CMS or EOHHS deems necessary to adequately monitor and evaluate the financial strength of the Contractor or that must be provided to CMS or EOHHS by law. Such information shall include, but not be limited to, the quarterly revenue expenses and utilization reports set forth in **Appendix A**; the annual financial ratios set forth in **Appendix A**; and the annual outstanding litigation report set forth in **Appendix A.**

L. Reporting

The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 2.15 and Appendix A**, in accordance with specified timetables, definitions, formats, assumptions, and certifications, as well as any ad hoc financial reports required by EOHHS.

M. Federally Qualified Health Centers

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 MassHealth 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.

N. HCPC Use

1. For all allowable individual medical visits, nurse-midwife medical visits, and group medical visits furnished at FQHCs and RHCs, the Contractor shall use the Health Care Common Procedure Code (HCPC), T1015, T1015-TH or T1015-HQ respectively, specified in 101 CMR 304.00, et seq., and shall use no alternative codes for the same or similar services.

2. For all allowable individual mental health visits (as defined in 101 CMR 304.02) furnished at FQHCs and RHCs, the Contractor shall use the Health Care Common Procedure Code (HCPC), G0469 and G0470 for new and established patients respectively, specified in 101 CMR 304.00, et seq., and shall use no alternative codes for the same or similar services.

O. Vaccine Administration

The Contractor shall not pay more for vaccine administration than permitted under federal

regulations, see Federal Register of October 3, 1994, RIN 0938-AG77 (Vaccine for Children Program).

P. Critical Access Hospitals

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

Section 2.16 Performance Evaluation

The Contractor shall:

A. Participate in the development of Quality Improvement (QI) Goals, measures and time frames with EOHHS. EOHHS and the Contractor shall finalize and incorporate into this Contract within 60 days of the Contract Effective Date such QI Goals, measures and time frames as **Appendix B, Quality Improvement Goals**. Beginning with CY 2012, QI Goals, measures, and time frames shall be incorporated into this Contract as **Appendix B** by January 1st of each Contract Year;

B. Meet the Quality Improvement Goals contained in **Appendix B** in accordance with the measures contained in **Appendix B**;

C. Actively participate in EOHHS work groups that develop strategies to meet Quality Improvement Goals and Contract requirements and to address other EOHHS initiatives. Such activities shall be proposed by EOHHS or the Contractor and shall be prioritized by EOHHS;

D. Actively participate in the annual Quality Improvement (QI) Goal meeting with EOHHS, for the primary purpose of reviewing progress toward the achievement of annual Improvement Goals and applicable Contract requirements, including, but not limited to, progress made toward measures and objectives and the timeliness and accuracy of the reporting requirements set forth in **Appendix B**;

E. Participate in EOHHS's annual External Quality Review (EQR) in accordance with **Sections 2.13.C.2 and 3.1.B.3**; and

F. Meet with EOHHS if EOHHS determines that the Contractor is not in substantial compliance with the Contract, including the biennial QI Goals set forth in **Appendix B.**

Section 2.17 Operational Audits

A. The Contractor or its Material Subcontractor shall cooperate and facilitate EOHHS's conduct of periodic on-site visits as described under **Section 5.4** of this Contract. At the time of such visits, the Contractor or Material Subcontractor shall assist EOHHS or its designee in activities pertaining to an assessment of all facets of the Plan's operations, including, but not limited to financial, administrative, clinical, pharmacy and claims processing functions and the verification of the accuracy of all data submissions to EOHHS as described herein.

B. The Contractor or Material Subcontractor shall respond to requests for information associated with such on-site visits in a timely manner, and shall make senior managers available for on-site reviews.

Section 2.18 Additional Enrollee Groups

A. Consistent with **Section 3.6**, EOHHS may require the Contractor to accept additional Enrollees into the Contractor's Plan including, but not limited to, Enrollees with Medicare or other third party health insurance or new expansion populations.

B. The Contractor shall cooperate with EOHHS to develop an implementation strategy for providing services to any new Enrollee group.

Section 2.19 Benefit Coordination

A. General Requirements

The Contractor shall:

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. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

3. Perform Benefit Coordination in accordance with this **Section 2.19**. The Contractor shall work with EOHHS via interface transactions with the MMIS system using HIPAA standard formats to submit information with regard to TPL investigations and recoveries.

B. Third Party Health Insurance Information

1. The Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance and (2) identify other health insurance that may be obtained by an Enrollee, in accordance with **Appendix H**, using, at a minimum, the following sources:

   a. The HIPAA 834 Outbound Enrollment File (for more information on this interface with MMIS and all interfaces, see **Section 2.14.E.5.c**.);

   b. Claims Activity;

   c. Point of Service Investigation (Customer Service, Member Services and Utilization Management); and

   d. Any TPL information self-reported by an Enrollee.

2. At a minimum, such procedures shall include:

a. Performing a data match against the Contractor's subscriber/member list for any other product line it offers and providing this information to EOHHS or its designee in accordance with **Appendix H**; and

b. Reviewing claims for indications that other insurance may be active (e.g. explanation of benefit attachments or third party payment).

C. Third Party Health Insurance Cost-Avoidance, Pay and Recover Later and Recovery

1. Once an Enrollee is identified as having other health insurance, the Contractor must cost avoid claims for which another insurer may be liable, except in the case of prenatal and EPSDT services per 42 USC 1396(a)(25)(E) and 42 CFR 433.139.

2. 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 a 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 the other insurance.

3. EOHHS shall provide the Contractor with all third party health insurance information on Enrollees where it has verified that third party health insurance exists, in accordance with **Section 3.2.**

4. The Contractor shall perform the following activities to cost-avoid, pay and recover later, or recover claims when other health insurance coverage is available:

a. Cost-Avoidance

The Contractor shall:

1) On the Daily Inbound Demographic Change File provide all third party liability information on the Contractor's Enrollees;

2) Pend claims that are being investigated for possible third party health insurance coverage in accordance with EOHHS's guidelines as described in **Appendix H**;

3) Deny claims submitted by a Provider when the claim indicates the presence of other health insurance;

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

5) Distribute TPL Indicator Forms at the Contractor's Provider orientations.

b. Pay and Recover Later

The Contractor shall take all actions necessary to comply with the requirements of 42 USC 1396a(a)(25)(E) and 42 CFR 433.139.

c. Recovery

The Contractor shall:

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) Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable in accordance with EOHHS's guidelines as described in **Appendix H**; and

3) Develop procedures and train staff to ensure that Enrollees who have comprehensive third party health insurance are identified and reported to EOHHS.

5. Reporting

Semi-annually, the Contractor shall report to EOHHS the following, in accordance with the requirements set forth in **Appendix A**:

a. 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;

b. Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 USC 1396a(a)(25)(E) and 42 CFR 433.139;

c. 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 semi-annual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and

d. 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 semi-annual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or Provider.

D. Accident and Trauma Identification and Recovery

1. Identification

a. Claims Editing and Reporting

The Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other third party liability cases:

1) Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;

2) Provider Notification – Claims where Providers have noted accident involvement; and

3) Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident. Questionnaires will be based on a predetermined diagnosis code range.

b. Medical Management

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. Reporting

On a semi-annual basis, the Contractor will provide EOHHS with cost avoidance and recovery information on accidents and trauma cases as specified in **Appendix A.**

3. Cost Avoidance and Recovery

The Contractor shall recover or cost-avoid claims where an Enrollee has been involved in an accident or lawsuit in accordance with **Appendix H**.

Section 2.20 Alternative Payment Methodologies

As further specified by EOHHS, the Contractor shall ensure, and demonstrate to EOHHS' satisfaction, that a minimum proportion of the Contractor's Enrollees receive care under Alternative Payment Methodologies, as follows:

A. Such minimum proportion of the Contractor's Enrollees shall be:

1. In Contract Years 1 and 2, sixty percent (60%) of the Contractor's Enrollees;
2. In Contract Years 3 and 4, seventy percent (70%) of the Contractor's Enrollees;
3. In Contract Year 5, eighty percent (80%) of the Contractor's Enrollees;

B. EOHHS shall consider an Enrollee to be receiving care under an Alternative Payment Methodology if:

1. The Enrollee is attributed for some portion of the Contract Year to a Network Provider, ACO, or other entity for the purposes of a shared savings/shared risk arrangement, for which the Contractor is eligible to make or receive a performance-based payment;
2. The Enrollee receives care during the Contract Year that the Contractor pays for using a bundled payment; or
3. The Enrollee otherwise receives care as part of an Alternative Payment Methodology in EOHHS' determination;

C. EOHHS shall consider Enrollees that are Attributed Members (as defined in Appendix P) of an MCO-Administered ACO with which the Contractor has an Approved ACO Agreements as described in Section 2.21 and as further specified by EOHHS to count an additional one hundred percent (100%) towards the Contractor's minimum proportion requirement as described above, such that EOHHS shall consider each percent (1%) of the Contractor's Enrollees that is so attributed to be equivalent to two percent (2.0%) of the Contractor's Enrollees for the purposes of such minimum proportion requirement;

D. The Contractor shall provide all requested documentation to EOHHS to demonstrate the Contractor's compliance with this Section of the Contract, including but not limited to documentation such as:

1. Details of the Contractor's Alternative Payment Methodologies;
2. Copies of the Contractor's Alternative Payment Methodology contracts;
3. Algorithms and data used by the Contractor, Network Providers, or other entities to associate Enrollees to the Contractor's Alternative Payment Methodologies, such as but not limited to attribution algorithms, attributed member rosters, utilization data, and payment bundling logic;
4. Records of payments made or received under the Contractor's Alternative Payment Methodologies; and
5. Other documentation as requested by EOHHS; and

E. The Contractor shall report on the Contractor's Alternative Payment Methodologies in a form and format and at a frequency specified by EOHHS, including reporting information such as but not limited to:

1. A list of the Contractor's Alternative Payment Methodology contracts and the Network Providers, ACOs, or other entities involved in each such contract; and
2. The total amount paid by the Contractor for Enrollee care under Alternative Payment Methodologies, as a total and as a percent of the total amount paid by the Contractor for Enrollee care.

Section 2.21 MCO-Administered ACOs

A. The Contractor shall, at all times during Contract Year 1, maintain Approved ACO Agreements as described in this section and as further specified by EOHHS, with all MCO-Administered ACOs present in the Contractor's Regions, in EOHHS determination.

B. If at least one MCO-Administered ACO is present in the Contractor's Regions, in EOHHS' determination, the Contractor shall, at all times after Contract Year 1, maintain at least one Approved ACO Agreement, as described in this Section and as further specified by EOHHS, with at least one such MCO-Administered ACO.

C. Such Approved ACO Agreements shall be considered Alternative Payment Methodology contracts for the purposes of **Section 2.20** and shall:

1. Meet all requirements in **Appendix P**, including requirements related to care delivery, care coordination and Care Management; Enrollee protections; and Total Cost of Care accountability;

2. Be subject to review and prior approval by EOHHS;

3. Not in any way replace, modify, or invalidate any responsibilities the Contractor has under this Contract; and

4. Satisfy any other requirements specified by EOHHS.

D. For every MCO-Administered ACO with which the Contractor has an Approved ACO Agreement, the Contractor shall, throughout the term of the Approved ACO Agreement, have as Network PCPs all the Participating PCPs for each such MCO-Administered ACO.

E. If no such MCO-Administered ACO is present in the Contractor's Regions, in EOHHS' determination, the Contractor shall not be required to enter into an Approved ACO Agreement with an MCO-Administered ACO as described above.

F. As set forth in **Appendix P** and as further specified by EOHHS, the Contractor shall support MCO-Administered ACOs with which it has Approved ACO Agreements as further specified by EOHHS. Such supports may include, but shall not be limited to, supports such as the following:

1. Data supports, such as a list of the Enrollees attributed to each MCO-Administered ACO and periodic updates to such list;

2. Assistance identifying high risk Enrollees, including Enrollees who may benefit from Care Management activities; and

3. Financial model technical assistance, such as education and support explaining the total cost of care financial model for MCO-Administered ACOs.

G. As set forth below and further specified by EOHHS, the Contractor shall:

1. Assign Enrollees to MCO-Administered ACOs as further directed by EOHHS;

2. Inform Enrollees assigned to MCO-Administered ACOs of their assignment to the MCO-Administered ACO as further directed and approved by EOHHS; and

3. Report any changes in MCO-Administered ACO contracts as further specified by EOHHS.

Section 2.22 Contractor COVID-19 Efforts

The Contractor shall, as set forth in this Contract and as further directed by EOHHS, help manage the 2019 novel Coronavirus (COVID-19) as set forth in this section.

A. As further specified by EOHHS, the Contractor shall help manage COVID-19 for at least the duration of the state of emergency declared via Executive Order No. 591 that began on March 10, 2020, and as set forth in MassHealth bulletins, including but not limited to MassHealth managed care entity bulletins, and other MassHealth guidance. Such activities to help manage COVID-19 shall include, but may not be limited to:

1. Taking all necessary steps to enable Enrollees to obtain medically necessary and appropriate testing and treatment.

2. Delivering all MCO Covered Services in an amount, duration and scope that is no more restrictive than the MassHealth fee-for-service program, and staying up to date on any changes to the amount, duration, and scope of services that MassHealth may announce via bulletins or guidance.

3. Conforming coverage policies of COVID-19 testing, treatment, and prevention, including specific coding and payment policies, with that of MassHealth through its fee-for-service program, including but not limited to as set forth in MassHealth's *All Provider Bulletin 289*, as may be updated from time to time.

4. Aligning pharmacy coverage, policies and procedures with the MassHealth fee-for-service program, as set forth in MassHealth bulletins or guidance, as may be updated from time to time, including but not limited to policies related to prescribing, dispensing, refills, prior authorization, and "contactless" transactions for the pick-up or delivery of drugs.

5. Minimizing barriers to prompt testing and treatment, such as relaxing referral, prior approval, and out-of-network requirements, including but not limited to not imposing any referral requirements for testing or treatment related to COVID-19.

6. Communicating, with EOHHS prior approval, relevant benefits, prevention, screening, testing, and treatment options to Enrollees and guidelines for contacting an Enrollee's local board of health or health care provider.

7. Covering outpatient COVID-19 testing, evaluation, and treatment services provided by out-of-network providers for the duration of the COVID-19 emergency. The Contractor shall also cover follow-up care provided by out-of-network providers when such follow-up care is not available in the Contractor's Provider Network. When such follow-up care is available in-

network, the Contractor may choose whether to cover such follow-up care provided by out-of-network providers or require out-of-network providers who provide these services to Enrollees to subsequently refer the enrollee back to the Contractor for follow-up care within the Contractor's Provider Network. In the case of services rendered by Federally Qualified Health Centers, the Contractor shall comply with **Sections 2.6.B.1.d.6** and **2.15.M**.

B. The Contractor shall institute the rate increases as set forth in this section and **Appendix Z** and as further described in MassHealth's *Managed Care Entity Bulletins*, as may be updated from time to time.

1. Appendix Z Rate Increases

a. For services set forth in **Appendix Z**, the Contractor shall establish payment rate increases as set forth in **Appendix Z**. Such rate increases shall apply to services delivered in-person and via telehealth, as applicable.

b. The Contractor shall apply the percentage increases indicated in **Appendix Z** to the Contractor's current contracted rates with providers, regardless of whether those rates are the same as the MassHealth fee-for-service rates. For any service already subject to a directed payment requirement, the Contractor shall apply the rate increases set forth in **Appendix Z** to the directed payment amount set forth in this Contract.

c. The Contractor shall implement these rate increases and begin disbursing funds to providers by the date set forth in **Appendix Z**. The Contractor shall pay the increased rate for services delivered on or after the rate increase effective date in the table at **Appendix Z**, including claims submitted prior to the effective date of this bulletin.

2. Inpatient Mental Health Services and Administratively Necessary Days (AND) Rate Increase

The Contractor shall increase rates for Inpatient Mental Health and AND Services delivered by DMH-licensed psychiatric hospitals and DMH-licensed psychiatric units within acute inpatient hospitals as follows and as further directed by EOHHS:

a. The Contractor shall increase its rate for Inpatient Mental Health and AND Services at DMH-licensed psychiatric hospitals and DMH-licensed psychiatric units within acute inpatient hospitals that have been designated as Tier 1 facilities by $94 per diem. The Contractor shall apply the Tier 1 rate increase for dates of service on or after April 1, 2020, through July 31, 2020, for providers identified by EOHHS as having met the prompt submission requirements set forth by DMH and EOHHS.

b. The Contractor shall increase its rate for Inpatient Mental Health and AND Services at DMH-licensed psychiatric hospitals and DMH-licensed psychiatric units within acute inpatient hospitals that have been designated as Tier 2 facilities by:

1) $94 per diem for dates of service April 1, 2020, through May 26, 2020;

2) $188 per diem for dates of service May 27, 2020, through July 31, 2020; and

3) $94 per diem for dates of service starting August 1, 2020, through October 31, 2020.

3. The Contractor shall apply the rate increases set forth in **Section 2.22.B.1** through the date set forth in **Appendix Z**, or as otherwise directed by EOHHS.

4. The Contractor shall report on expenditures attributed to the rate increase requirements described in this Section as set forth in Appendix A, in a form and format and at a time specified by EOHHS.

5. If the Contractor has sub-capitated or Alternative Payment Methodology (APM) arrangements with providers for the provision of any services subject to rate increases pursuant to this section, the sub-capitated or APM payments to providers should be increased by the equivalent of the rate increases that would be required for fee for service payments as set forth in this section.

6. The Contractor shall not subject the required rate increases to any withhold arrangement with providers and will ensure that providers receive the full rate increases in payments set forth in this section.

7. All encounter file claim paid amounts with dates of service as of the rate increase effective date directed by EOHHHS must reflect the specified rate increases.

8. The Contractor shall certify on a monthly basis in a form and format specified by EOHHS, as set forth in **Appendix A**, to compliance with any of these rate increase requirements as directed by EOHHS. Such certification shall include certification that the Contractor has made timely payments which include these required increases, with no offsets to provider payments through withholds, sub-capitated payment arrangements or other APMs.

C. The Contractor shall establish provider rates equal to the MassHealth fee schedule for the services related to COVID-19 specimen collection and testing set forth in **Appendix Z**, and as further described in MassHealth's *Managed Care Entity Bulletins*, as may be updated from time to time, and other MassHealth guidance. The Contractor shall make these minimum payments beginning on the dates set forth in **Appendix Z** through the duration of the state of emergency declared by Executive Order No. 591, or as otherwise directed by EOHHS.

SECTION 3. EOHHS RESPONSIBILITIES

Section 3.1 Contract Management

A. Administration

EOHHS shall:

1. Designate an individual authorized to represent EOHHS regarding all aspects of the Contract. EOHHS' representative shall act as a liaison between the Contractor and EOHHS during the Contract Term. The representative shall be responsible for:

    a. Monitoring compliance with the terms of the Contract;

    b. Receiving and responding to all inquiries and requests made by the Contractor under this Contract;

    c. Meeting with the Contractor's representative on a periodic or as-needed basis for purposes including but not limited to discussing issues which arise under the Contract; and

    d. Coordinating with the Contractor, as appropriate, on Contractor requests for EOHHS staff to provide assistance or coordination on Contractor responsibilities;

2. Review, approve and monitor the Contractor's outreach and orientation materials, MassHealth Member Handbook, marketing materials, wellness program materials, and Complaint, Grievance and Appeals procedures;

3. If it determines that the Contractor is in violation of any of the terms of the Contract stated herein, at its sole discretion, apply one or more of the sanctions provided in **Section 5.3.K.2,** including termination of the Contract in accordance with **Section 5.5;** provided, however, that EOHHS shall only impose those sanctions that it determines to be reasonable and appropriate for the specific violation(s) identified;

4. At its discretion, conduct annual validity studies to determine the completeness and accuracy of Encounter Data including comparing utilization data from medical records of Enrollees (chosen randomly by EOHHS) with the Encounter Data provided by the Contractor. If EOHHS determines that the Contractor's Encounter Data are less than 99% complete or less than 95% accurate, EOHHS will provide the Contractor with written documentation of its determination and the Contractor shall be required to implement a corrective action plan to bring the accuracy to the acceptable level. EOHHS may conduct a validity study following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Contractor has attained 99% completeness. EOHHS, at its discretion, may impose intermediate sanctions or terminate the Contract if the Contractor fails to achieve a 95% accuracy level following completion of the corrective action plan as determined by the validity study or as otherwise determined by EOHHS;

5. At its discretion, conduct periodic on-site visits as described under **Sections 2.17** and **5.4** of this Contract. At the time of such visits, the Contractor shall assist EOHHS in activities pertaining to an assessment of all facets of the 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;

6. If it determines that the Contractor is out of compliance with **Section 5.1.G** of the Contract, 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; and

7. 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 2.8.H.1.f**.

B. Performance Evaluation

EOHHS shall, at its discretion:

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 2.13.C**.

   On an ongoing basis, monitor and evaluate the Contractor's compliance with the terms of this Contract, including, but not limited to, the reporting requirements in **Appendix A** and the performance measurement and performance improvement projects set forth in **Sections 2.13.C. 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 such evaluations, including, at its discretion, a quarterly scorecard that shows how the Contractor has performed relative to its own previous quarter's performance and relative to the MassHealth-contracted MCO average. EOHHS will also, at its discretion, provide the Contractor with an annual score for the reports submitted in accordance with **Appendix A** and a biennial score for the reports submitted in accordance with **Appendix B.**

2. Conduct periodic audits of the Contractor, as further described in **Section 6.4**, including, but not limited to, annual External Quality Review Activities, as specified in **Section 2.13.C.2,** and an annual operational review site visit pursuant to **Section 2.17**.

3. Conduct biennial Member satisfaction surveys and provide the Contractor with written results of such surveys.

4. 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.

Section 3.2 Coordination of Benefits

A. 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.

B. 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.

C. EOHHS shall develop Base Capitation Rates that are net of expected TPL recoveries, consistent with the Contractor's obligation under this Contract, including **Section 2.19**, to recover claims paid to Providers where the other insurer was primary.

Section 3.3 Enrollment, Assignment, and Disenrollment Process

A. Enrollment Verification

EOHHS shall verify and inform the Contractor of each Enrollee's eligibility and enrollment status in the Contractor's Plan, through the Eligibility Verification System (EVS) and through the HIPAA 834 Outbound Enrollment file.

B. Enrollment

EOHHS shall:

1. Maintain sole responsibility for the enrollment of Members into the Contractor's Plan, as described in this **Section 3.3**. EOHHS shall present all options available to Members under MassHealth in an unbiased manner and shall inform each Member at the time of enrollment, of their right to terminate enrollment at any time;

2. On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Daily Enrollment file, information pertaining to all enrollments, including the Effective Date of Enrollment, which will be updated on a daily (business day) basis;

3. At its discretion, automatically re-enroll on a prospective basis in the Contractor's Plan, Members who were disenrolled due to loss of eligibility and whose eligibility was reestablished by EOHHS;

4. Make best efforts to provide the Contractor with the most current demographic information available to EOHHS. Such demographic data shall include, when available to EOHHS, the Enrollee's name, address, MassHealth identification number, date of birth, telephone number, race, gender, ethnicity, and primary language; and

5. Review and respond to written complaints from the Contractor about the CSC Enrollment Vendor within a reasonable time. EOHHS may request additional information from the Contractor in order to perform any such review.

C. Disenrollment

1. Disenrollment Conditions

a. EOHHS shall disenroll an Enrollee from the Contractor's Plan and he or she shall no longer be eligible for services under such Plan following:

1) Loss of MassHealth eligibility;

2) Completion of the Enrollee's voluntary disenrollment request;

3) EOHHS approval of a request by the Contractor for involuntary disenrollment pursuant to **Section 2.4.D.** herein; or

4) Loss of eligibility for MassHealth Managed Care as indicated in 130 CMR 508.002 which includes but is not limited to Enrollees receiving continuing inpatient psychiatric care.

b. Except as otherwise provided under federal law or waiver, an Enrollee may disenroll voluntarily:

1) For cause, at any time, in accordance with 42 CFR 438.56(d)(2) and 130 CMR 508.003(C)(3); and

2) Without cause, at any time during a plan selection period as set forth in 130 CMR 508.003(C)(1);

2. Disenrollment Information

EOHHS shall:

a. On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Enrollment File, information pertaining to all disenrollments, including the Effective Date of Disenrollment and the disenrollment reason code; and

b. Provide the Contractor with information related to the following voluntary disenrollment reasons as received from Enrollees by the CSC Enrollment Vendor on a monthly basis. Such disenrollment reasons may include, but are not limited to:

1) Difficult to contact PCP;

2) Takes too long to obtain an appointment;

3) Did not like the PCP;

4) Dissatisfaction with Behavioral Health Services;

5) Did not like office staff's personal manner;

6) Received poor medical treatment; and

7) Any other specified causes.

Section 3.4 Customer Service Center (CSC) Enrollment Vendor

EOHHS or its designee shall assign a staff person(s) who shall have responsibility to:

A. Develop generic materials to assist Members in choosing whether to enroll in the Contractor's Plan, another Accountable Care Partnership Plan, a MassHealth-contracted MCO, or the PCC Plan. Said materials shall present the Contractor's Plan in an unbiased manner to Members eligible to enroll in the Contractor's Plan. EOHHS may collaborate with the Contractor in developing Plan-specific materials;

B. Present the Contractor's Plan in an unbiased manner to Members in the Contractor's Regions who are newly eligible for Managed Care or seeking to transfer from one Managed Care plan to another plan. Such presentation(s) shall ensure that Members are informed prior to enrollment of the following:

1. The nature of the requirements of participation in an MCO, including but not limited to:

a. Use of Network Providers;

b. Maintenance of existing relationships with Network Providers; and

c. The importance of Primary Care;

2. The nature of the Contractor's medical delivery system, including, but not limited to the Provider Network; ability to accommodate non-English speaking Enrollees; referral system; and, requirements and rules which Enrollees must follow once enrolled in the Contractor's Plan; and

3. Orientation and other Member services made available by the Contractor;

C. Enroll, disenroll and process transfer requests of Enrollees in the Contractor's Plan, including completion of EOHHS's enrollment and disenrollment forms, except enrollment forms for newborn Enrollees;

D. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment under MassHealth regulations, and federal law or waiver;

E. Be knowledgeable about the Contractor's policies, services, and procedures;

F. At its discretion, develop and implement processes and standards to measure and improve the performance of the CSC Enrollment Vendor staff. EOHHS shall monitor the performance of the CSC Enrollment Vendor; and

G. Invite all MassHealth-contracted MCOs and Accountable Care Partnership Plans in the Regions to participate in EOHHS-sponsored Health Benefit Fairs.

Section 3.5 Marketing

EOHHS shall:

A. Monitor the Contractor's Marketing activities and distribution of related materials; and

B. Within fifteen (15) business days of receipt of Marketing Material submitted by the Contractor in compliance with **Section 2.11.A.3**, take one of the following actions:

1. Approve or disapprove the Marketing Material;

2. Require modification to the Marketing Material; or

3. Notify the Contractor that EOHHS requires an additional ten (10) business days from the date of such notification to take the actions described in **B.1 or B.2** above.

The Contractor shall comply with any such EOHHS action. EOHHS's failure to take any of the actions described in **B.1, 2 or 3** above within 30 business days after receipt of the Contractor's Marketing Material, shall be deemed to constitute approval of said Marketing Material. Further, EOHHS's failure to take any of the actions described in **B.1 or B.2** above within ten (10) business days after notification of the Contractor in accordance with **B.3**, shall be deemed to constitute approval of the Marketing Material, as shall EOHHS's failure to respond within ten (10) business days of receipt of modifications to Marketing Materials submitted to EOHHS pursuant to **B.2** above.

Section 3.6 Additional Enrollee Groups

EOHHS may:

A. Develop and implement, in consultation with other entities such as but not limited to other Accountable Care Partnership Plans and MassHealth-contracted MCOs, necessary processes and procedures required to implement enrollment of additional Enrollee groups, as further specified by EOHHS;

B. Develop a benefit package for any such Enrollee group which to the extent practicable is consistent with MCO Covered Services for other Enrollee groups;

C. Inform the Contractor regarding demographic characteristics and utilization experience of any new Enrollee group prior to initiation of enrollment to the extent that such information is available;

D. Develop a Capitation Rate(s) for such Enrollee group(s) consistent with 42 CFR 447.361 and in consultation with the MassHealth-contracted MCOs; and

E. Develop, in cooperation with the Contractor, an implementation strategy for providing services to Enrollees.

Section 3.7 Community Partner Certification

EOHHS shall certify Community Partners and notify Contractor of available certified Community Partners.

Section 3.8 MCO-Administered ACOs

EOHHS shall identify for the Contractor the MCO-Administered ACOs that are present in the Contractor's Regions, if any, for the purposes of the requirements in **Section 2.21.**

SECTION 4. PAYMENT AND FINANCIAL PROVISIONS

Section 4.1 Managed Care Organization Rating Categories

Subject to all required federal approvals, EOHHS shall pay the Contractor, in accordance with Section 4, by the designated Coverage Type, for providing MCO Covered Services to Enrollees in the following Rating Categories (RCs): RC I Child, RC I Adult, RC II Child, RC II Adult, RC IX (Adults only), and RC X (Adults only). Enrollees are eligible for MCO and Non-MCO Covered Services described in **Appendix C**, as appropriate, depending upon such Enrollee's Coverage Type.

A. RC I Child

RC I Child includes Enrollees who are non-disabled, under the age of 21, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505

B. RC I Adult

RC I Adult includes enrollees who are non-disabled, age 21 to 64, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505.

C. RC II Child

RC II Child includes Enrollees who are disabled, under the age of 21, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

D. RC II Adult

RC II Adult includes Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

E. RC IX

RC IX includes Enrollees who are age 21 to 64, and in CarePlus as described in 130 CMR 505 who are not receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. RC IX shall also include Enrollees who have identified themselves to MassHealth as medically frail in accordance with 130 CMR 505.008(F), and therefore are in the MassHealth Standard coverage type.

F. RC X

RC X includes Enrollees who are age 21 to 64, and in CarePlus as described in 130 CMR 505 who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance.

Section 4.2 Payment Methodology

A. General

EOHHS shall make payment to the Contractor for MCO Covered Services provided under this Contract, in accordance with the payment provisions in this Section 4 and the Base Capitation Rates contained in Appendix D.

B. Base Capitation Rates for Contract Year 1

1. In Contract Year 1 (i.e. 2018), in accordance with 42 CFR 438.4, beginning on the Contract Operational Start Date, Base Capitation Rates for each Rating Category and Region for which the Contractor provides MCO Covered Services shall be Actuarially Sound.

2. These Base Capitation Rates shall be Region-specific for each of the five Regions. Regions are comprised of Service Areas. A Service Area may span across more than one Region.

3. Base Capitation Rates shall be incorporated into the Contract in Appendix D. Base Capitation Rates shall be comprised of the Medical Component of the Capitation Rate, and the Administrative Component of the Capitation Rate. The Medical Component shall consist of the HCV Component, the Non-HCV High Cost Drug Component, and the non-High-Cost Drug/Non-HCV Medical Component. The Administrative Component of the Base Capitation Rate shall reflect the applicable cost of administering medical benefits, underwriting gain, care management, and any other non-medical costs not otherwise paid for under the Contract.

C. Base Capitation Rates for Subsequent Contract Years

1. After the first Contract Year, EOHHS shall annually develop the Base Capitation Rates for each Rating Category in each Region.

2. EOHHS shall meet with the Contractor annually, upon request, to announce and explain the Base Capitation Rates, including the Medical Component and Administrative Component of the Base Capitation Rates.

3. EOHHS intends that the Base Capitation Rates shall be consistent for all Managed Care Organizations; provided, however, that EOHHS may provide a different Base Capitation Rate to a Managed Care Organization, in EOHHS's discretion, to account for unique circumstances.

4. Prior to the beginning of the Contract year, EOHHS shall incorporate, by amendment, the Base Capitation Rates by RC and Region into the Contract at Appendix D, Exhibit 1; provided, however, that EOHHS may amend the Base Capitation Rates by RC at such other times as may be necessary as determined by EOHHS, or as a result of changes in federal or state law, including but not limited to, to account for changes in eligibility, covered services, or copayments.

D. Failure to Accept Base Capitation Rates

1. In the event that the Contractor does not accept the Base Capitation Rates for the new Contract Year at a minimum of 21 days prior to the first day of the new Contract Year, EOHHS

will continue to pay the Contractor the prior year's Risk Adjusted Capitation Rates and the Contractor shall accept such payment as payment in full under the Contract subject to paragraphs a. and b. below. EOHHS may also halt all new Enrollee assignments to the Contractor's Plan until the Contractor accepts the Base Capitation Rates offered by EOHHS.

a. In the event that the prior year's Risk Adjusted Capitation Rates are higher than the Risk Adjusted Capitation Rates for the new Contract Year that the Contractor ultimately accepts, EOHHS may recoup the higher Capitation payments made during the interim period.

b. In the event that the prior year's Risk Adjusted Capitation Rates are lower than the Risk Adjusted Capitation Rates for the new Contract Year and the Contractor does not accept the Base Capitation Rates offered by EOHHS by the beginning of the new Contract Year, EOHHS will not retroactively adjust the Risk Adjusted Capitation Rate for the interim rate period.

c. In the event that the Contractor does not accept the Base Capitation Rates for the new Contract Year within 60 days following the end of the prior Contract Year, EOHHS may terminate the Contract.

2. If the Contractor does not accept the Base Capitation Rates, EOHHS may terminate the Contract and the Contractor shall be obligated to continue to provide MCO Covered Services to Enrollees, until such time as all Enrollees are disenrolled from the Contractor's Plan as described in **Section 6.5.C**. The Contractor shall accept the Risk Adjusted Capitation Rates in accordance with **Section 4.2.E** adjusted by EOHHS as it determines necessary to account for changes in eligibility, MCO Covered Services or cost sharing, as payment in full for MCO Covered Services delivered to Enrollees during such time.

E. Risk Adjusted Capitation Rates

EOHHS intends to risk adjust the Medical Component of the Base Capitation Rates beginning on the Contract Operational Start Date to reflect the different health status (acuity) of Enrollees enrolled in the Contractor's Plan. EOHHS shall use a statistical methodology to calculate diagnosis-based risk-adjusters using a generally accepted diagnosis grouper. Such risk adjustment shall be based on an aggregation of the individual risk scores of Enrollees enrolled in the Contractor's Plan. EOHHS intends to risk adjust the Medical Component of the Base Capitation Rates at least annually. The Risk Adjusted Capitation Rate shall equal the sum of the risk adjusted Medical Component, and the Administrative Component of the Base Capitation Rate, and any add-ons set forth in **Appendix D**. The Contractor shall accept as payment in full such Risk Adjusted Capitation Rates.

F. Estimated Capitation Payment Process

1. EOHHS shall make Capitation Payments for Enrollees in each Rating Category (RC) and Region as follows:

a. For each RC and Region, EOHHS shall calculate an estimated full month Capitation Payment on or about the third Friday of the month preceding the Payment Month based on estimated enrollment data for the Payment Month.

b. For Enrollees for whom EOHHS has assigned a specific disenrollment date due to a qualifying event such as a member attaining age 65 within the Payment Month, EOHHS shall make a prorated Estimated Capitation Payment to the Contractor. The prorated Estimated Capitation Payment will equal:

1) the Risk Adjusted monthly Capitation Rate multiplied by,

2) the number of days in the Payment Month that the member is enrolled up to and including the disenrollment date of the qualifying event divided by,

3) the total number of days in the Payment Month.

2. The Contractor shall be responsible for providing MCO Covered Services to such Enrollees as of the Effective Date of Enrollment in accordance with **Section 2.4.B**.

G. Coverage of Newborns

EOHHS shall enroll and retrospectively pay the Risk Adjusted Capitation Rate for a newborn effective on his or her date of birth provided that:

1. The mother was an Enrollee in the Contractor's MassHealth plan at the time of the birth;

2. The Notification of Birth (NOB) form was submitted by the hospital in accordance with **Section 2.4.C.2.;** and

3. The Contractor is in compliance with the other provisions of **Section 2.4.C**.

H. Non-Medical Programs and Services

Non-Medical Programs and Services, as defined in Section 1 of this Contract, shall not be recorded as medical service costs or administrative costs.

I. Indian Enrollees and Indian Health Care Providers

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 CFR 438.14.

1. The Contractor shall offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain MCO Covered Services from out-of-network Indian Health Care Providers from whom the enrollee is otherwise eligible to receive such services. The Contractor shall also permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider

2. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to MCO Covered Services for Indian Enrollees;

3. The Contractor shall pay both network and non-network Indian Health Care Providers who provide MCO Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee for service rate for the same service or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is greater, or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the MCO Covered Service provided by a non-Indian Health Care Provider or the MassHealth fee for service rate for the same service, whichever is greater;

4. The Contractor shall make prompt payment to Indian Health Care Providers; and

5. 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 CFR 438.14(c)(1).

J. Suspension of Payments

EOHHS may suspend payments to the Contractor in accordance with 42 CFR 455.23, et seq. and 130 CMR 450, et seq. as determined necessary or appropriate by EOHHS.

K. Non-Payment and Reporting of Provider Preventable Conditions

Pursuant to 42 CFR 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance with all provisions related to Provider Preventable Conditions, including but not limited to **Section 2.7.D.9.b** of the Contract.

Section 4.3 Adjustments or Additions to Payments

A. Health Insurer Provider Fee Adjustment

In accordance with CMS guidance, to account for the portion of the Contractor's Health Insurer Provider Fee under Section 9010 of the ACA (the HIPF) that is allocable to MassHealth premiums, if the Contractor is subject to such HIPF:

1. Each year, the Contractor shall provide EOHHS with information about the Contractor's HIPF, as requested by EOHHS, including but not limited to the bill the Contractor receives from the U.S. Internal Revenue Service.

2. EOHHS shall calculate and perform an adjustment set forth in Appendix D to the Contractor's Base Capitation Rates to account for the portion of the Contractor's HIPF that is allocable to MassHealth premiums and, subject to federal financial participation, for the tax liability related to the HIPF, if applicable.

3. If allowed by CMS for a given Calendar Year, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after October 1 of the following Calendar Year.

B. Supplemental Maternity Payment

EOHHS shall pay the Contractor a Supplemental Maternity Payment as follows and as further specified by EOHHS:

1. The Supplemental Maternity Payment shall be for the facility costs associated with inpatient MCO Covered Services for newborn deliveries. The costs associated with these MCO Covered Services shall be excluded from the development of the Base Capitation Rates and shall not be reflected in the Contractor's monthly Capitation payment. These associated costs, as well as the Supplemental Maternity Payment itself, shall also be excluded from all risk sharing arrangement calculations set forth in **Section 4.5**. As further specified by EOHHS, costs for the following remain in the data used to develop the Base Capitation Rates and are therefore reflected in the Contractor's monthly Capitation payment (and not in this Supplemental Maternity Payment): costs associated with stillborn deliveries, newborn costs associated with the delivery event, the professional component of the delivery event, prenatal care, post-partum care, or costs of inpatient care associated with any maternity cases that end in termination or miscarriage;

2. The Supplemental Maternity Payment shall be a set per-delivery rate. As further specified by EOHHS, EOHHS shall calculate the amount of the Contractor's Supplemental Maternity Payment by multiplying the number of eligible newborn deliveries by such per-delivery rate;

3. EOHHS shall pay the Contractor the Supplemental Maternity Payment quarterly or on another frequency specified by EOHHS;

4. To receive the Supplemental Maternity Payment, the Contractor shall:

    a. Report, in a form, format, and frequency specified by EOHHS, the number of eligible deliveries Contractor provided to Enrollees, and

    b. Provide supporting documentation requested by EOHHS, such as Encounter Data;

5. EOHHS shall review, request modification or additional information as necessary, and approve the Contractor's report and supporting documentation.

6. EOHHS may audit the Contractor's records to verify any information contained in any such report prior or subsequent to approving and making a Supplemental Maternity Payment. Such audit may result in recoupment from the Contractor of part or all of any Supplemental Maternity Payment; and

7. For the avoidance of doubt, the Contractor is responsible for providing all Medically Necessary MCO Covered Services to Enrollees as described in this Contract, including the MCO Covered Services reflected in this Supplemental Maternity Payment;

C. Supplemental Specialized Inpatient Psychiatric Services Payment

EOHHS shall pay the Contractor a Supplemental Specialized Inpatient Psychiatric Services Payment as follows and as further specified by EOHHS:

1. The Supplemental Specialized Inpatient Psychiatric Services Payment shall be for specialized inpatient psychiatric services to Enrollees under the age of 21 with Autism Spectrum Disorder or Intellectual or Developmental Disability (ASD/IDD) in specialized ASD/IDD inpatient psychiatric treatment settings;

2. The Supplemental Specialized Inpatient Psychiatric Services Payment shall be an additional per diem payment; as further specified by EOHHS;

3. The Supplemental Specialized Inpatient Psychiatric Services Payment shall not be included in the Non High Cost Drug/Non-HCV Medical Component of the Risk Adjusted Capitation Payment for risk sharing arrangement calculations set forth in **Section 4.5**. EOHHS may reprice the associated expenditures and include these repriced expenditures in the Non High Cost Drug/Non-HCV actual medical expenditures in risk sharing arrangement calculations set forth in **Section 4.5**.

4. EOHHS shall pay the Contractor the Supplemental Specialized Inpatient Psychiatric Services Payment yearly or at another frequency specified by EOHHS.

D. Disability Access Incentive for Acute Hospitals

1. At a frequency to be specified by EOHHS, EOHHS shall pay Contractor an amount equal to the sum of provider payments described in **Section 2.8.L.3** for the applicable time period.

2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.8.L.3**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4**.

E. Hospital Quality Incentive Payment

1. At a frequency to be specified by EOHHS, EOHHS shall pay Contractor an amount equal to the sum of provider payments described in **Section 2.8.L.3** for the applicable time period.

2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.8.L.3**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4**.

F. Other MCO-directed Incentive Programs

1. At a frequency to be specified by EOHHS, EOHHS shall pay Contractor an amount equal to the sum of provider payments tied to any other MCO-directed value-based incentive programs described in **Section 2.8.M** for the applicable time period.

2. For the Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.8.M**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4**.

G. Inpatient Mental Health Services

The rate increases for Inpatient Mental Health Services set forth in **Section 2.7.A.3.e.7**, shall not be included in the Non High Cost Drug/Non-HCV Medical Component of the Risk Adjusted Capitation Payment for risk sharing arrangement calculations set forth in **Section 4.5**. EOHHS may reprice the associated expenditures and include these repriced expenditures in the Non High Cost Drug/Non-HCV actual medical expenditures in risk sharing arrangement calculations set forth in **Section 4.5**.

H. Pharmacy Utilization Target Incentive

For Contract Year 2021, if the Contractor exceeds the higher bound of a utilization target set forth in **Section 2.6.B.4.e** for the Contract Year as described in **Section 2.6.B.4.e.5**, EOHHS shall pay the Contractor the amount of additional supplemental rebates collected by EOHHS for the Contract Year as a result of the Contractor exceeding such higher bound of the utilization target; provided, however, that EOHHS may calculate such amount at an individual utilization target level and shall then arrive at a final payment amount or final Capitation Payment deduction amount (in accordance with **Section 6.3.K.11**) by calculating in the aggregate across all utilization targets all instances where the Contractor did not meet the lower bound of such utilization targets and where the Contractor exceeded the higher bound of such utilization targets. Such final aggregate calculation may result in a payment to the Contractor or a Capitation Payment deduction. EOHHS shall provide the Contractor with a report showing such calculation at the aggregate level.

Section 4.4 Payment Reconciliation Process

A. Enrollment-related Reconciliations

1. EOHHS shall perform the following monthly reconciliations with a lookback period determined by EOHHS and adjust Estimated Capitation Payments as below:

   a. Enrollees Who Change Rating Categories During the Payment Months included in the lookback period

      EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total Estimated Capitation Payment issued to the Contractor for Enrollees who change Rating Categories during any of the Payment Months in the lookback period, and issue a pro-rated monthly capitation payment that reflects the actual number of Enrollee Days in any of the months in the lookback period for each of the affected Rating Categories.

   b. Enrollees Who Disenroll During the Payment Month

EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total Estimated Capitation Payment issued to the Contractor for Enrollees who disenroll from the Contractor's Plan during any of the Payment Months in the lookback period, and issue a pro-rated monthly capitation payment to reflect the actual number of Enrollee Days in any of the months in the lookback period.

c. Members Who Enroll During a Payment Month

For Members who enroll in the Contractor's Plan during the Payment Months in the lookback period but after the Estimated Capitation Payment has been issued to the Contractor for any of such Payment Months in the lookback period, EOHHS shall, in the month following the Payment Month, issue a pro-rated monthly capitation payment to reflect the actual number of Enrollee Days with respect to such Members for any of the payment months in the lookback period.

2. EOHHS shall perform an annual reconciliation of the Estimated Capitation Payments to adjust for any enrollment discrepancies not included in the monthly reconciliations with the lookback period determined by EOHHS;

3. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies pursuant to the reconciliations in this Section. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. The Contractor shall report any such overpayments to EOHHS within 60 calendar days of when the Contractor identifies the overpayment. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments as described in **Section 4**.

a. Overpayments - Overpayments shall constitute the amount actually paid to the Contractor for all Rating Categories in excess of the amount that should have been paid in accordance with EOHHS's reconciliation.

b. Underpayments – Underpayments shall constitute the amount not paid to the Contractor for all Rating Categories that should have been paid in accordance with EOHHS's reconciliation.

B. Family Planning Services Reconciliation Process

EOHHS shall perform an annual family planning services reconciliation as follows. EOHHS shall:

1. Calculate all FFS claims paid by EOHHS for family planning services, including family planning pharmacy services, provided to Enrollees in all RCs between the first and last day of each Contract Year; and

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.

C. Continuing Services Reconciliation

EOHHS shall perform an annual Continuing Services reconciliation as follows:

1. The Contractor shall process and pay its Providers' claims for all Continuing Services at the Contractor's contracted rate with its Providers.

2. EOHHS shall perform a reconciliation by June 30th, following the end of the Contract Year, to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by the BOH and which were provided following the conclusion of the Final Internal Appeal Decision ("approved Continuing Service claims"); provided that the Contractor submits to EOHHS by March 31st, following the end of the Contract Year, all data regarding such services as required in **Section 4.4.C.4** below.

3. EOHHS shall pay the Contractor no later than 12 months following the end of the Contract Year being reconciled, the total value of the approved Continuing Service claims referenced in **Section 4.4.C.2** above, that were provided within the applicable Contract Year, provided the Contractor timely submitted all data required by EOHHS pursuant to this Section 4.4.

4. Approved Continuing Service claims shall include, at a minimum, the following information:

    a. Enrollee information by MassHealth identification number, including date of birth, sex, dates of enrollment, the date on which the Continuing Services were provided, and current enrollment status;

    b. Costs incurred, by MassHealth identification number, including date of service; and

    c. Such other information as may be required pursuant to any EOHHS request for information.

5. 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. 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**.

D. Pharmacy Reconciliation

As further specified by EOHHS, EOHHS shall perform a reconciliation for payments made by EOHHS for pharmacy claims submitted to EOHHS between March 8, 2018 at 6:00 p.m. and March 15, 2018, at 11:59 p.m. EOHHS shall identify through such reconciliation the amount owed to EOHHS by the Contractor. The Contractor shall remit to EOHHS the full amount through recoupment from future capitation payments.

Section 4.5 Risk Sharing Arrangements

A. General Requirement

The Contractor shall participate in any risk-sharing arrangement as directed by EOHHS in each Contract Year.

B. General Provisions

1. Each risk sharing arrangement set forth in this **Section 4.5** shall be calculated separate from any other risk sharing arrangement in this **Section 4.5**. In performing calculations for any one risk-sharing arrangement set forth in this **Section 4.5**, EOHHS shall not include the Contractor's expenditures or EOHHS' payment to the Contractor for services applicable to any other risk-sharing arrangement.

2. The arrangement described in this Section may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor. Such payments may be accounted for in future capitation payments from EOHHS to the Contractor.

3. The Contractor shall submit the following data to assist EOHHS in calculating applicable medical expenditures for the risk sharing arrangements in this section,

    a. Encounter Data, as specified in this Contract;

    b. Reports submitted by the Contractor applicable to the risk sharing arrangement, including but not limited to those set forth in **Appendix A**;

    c. Within 212 days following the end of the Contract Year, a report, in a form and format specified by EOHHS, containing information related to actual medical expenditures for Enrollees, based on Claims incurred for the applicable Contract Year for the applicable risk sharing arrangement. Actual medical expenditures as submitted by the Contractor shall specifically exclude any and all administrative costs.

4. As further specified below, all payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS. The Contractor shall work with EOHHS, and submit any additional documentation as requested by EOHHS, to resolve any discrepancies in any calculations. After good faith efforts to resolve any discrepancies in any calculation with the Contractor, EOHHS shall make the final determination of any payment or calculation of such payment.

5. The Contractor shall submit all required data and documentation described in this **Section 4.5.B** by the deadline specified by EOHHS. EOHHS shall give prior written notice of such deadline. In the event the Contractor does not meet the deadline specified by EOHHS for such data and documentation, EOHHS may, in its sole discretion, either choose to not incorporate such data and documentation into risk corridor settlement for that particular Contract Year or may choose to incorporate such data and documentation but may impose the Capitation Payment deduction as set forth in **Section 6.3.K.5.b**.

C. Contract-Wide Risk Sharing Arrangement for the Contract Year

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for the Non-High-Cost Drug /Non-HCV Medical Component of the Risk Adjusted Capitated Rate in accordance with the following provisions.

1. Overall Approach

   All payments shall be calculated and determined by EOHHS based on the Contractor's actual Non-High-Cost Drug/Non- HCV medical expenditures relating to all Enrollees, and the Non-High-Cost Drug/Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment aggregated across all Regions by Rating Category groups set forth in **Appendix D, Exhibit 3**.

2. Non-High-Cost-Drug/Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment

   EOHHS shall first determine the Non-High-Cost Drug/Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the applicable Contract Year aggregated across all Regions by Rating Category groups set forth in **Appendix D, Exhibit 3**. The Contractor's Non-High-Cost Drug/Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall mean the sum of the Monthly Risk Adjusted Capitation Payments actually paid by the EOHHS for each month of the Contract Year aggregated across all Regions by Rating Category groups set forth in **Appendix D, Exhibit** 3, as determined by the EOHHS, less, across all Regions by Rating Category groups, the risk adjusted HCV Component, risk adjusted High-Cost Drug component, the CBHI Add-on, the ABA Add-on, the SUD Risk Sharing Services Add-on, and the Administrative Component of such payments utilizing the amount set forth in **Appendix D**, per member, per month.

3. Non-High Cost Drug/Non-HCV actual medical expenditures

   EOHHS shall then determine the Contractor's Non-High-Cost Drug/Non-HCV actual medical expenditures in aggregate across all Regions by Rating Category groups set forth in **Appendix D, Exhibit 3** related to the provision of MCO Covered Services in **Appendix C** for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.B** above, and may verify such data in a manner it determines appropriate.

   a. Expenditures shall exclude any and all case management costs.

   b. For the reports specified in **Section 4.5.B.3** above, the Contractor shall include 6 months of Claims run-out.

4. If the Contractor's Non-High-Cost Drug/Non-HCV actual Medical Expenditures, as determined by EOHHS in accordance with the above provisions, in the aggregate across all Regions by Rating Category groups set forth in **Appendix D, Exhibit 3** is greater than or less than the Non-High-Cost Drug /Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year in the aggregate across all Regions by Rating Category groups set forth in **Appendix D, Exhibit 3**, the Contractor and EOHHS shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Appendix D**.

5. If the Contractor incurs a loss for any Rating Category group set forth in **Appendix D, Exhibit 3** that would require EOHHS to make a risk sharing payment to the Contractor, and the Contractor has paid an amount in aggregate across all Regions for that Rating Category group for MCO Covered Services that exceeds the amount that EOHHS would have paid in the aggregate across all Regions for that Rating Category group for the same services in accordance with EOHHS's fee schedule, then EOHHS may reprice the Contractor's paid Claims for that Rating Category group to reflect EOHHS's fee schedule for the purposes of calculating the risk-sharing payment described in this section. If such repricing results in the Contractor incurring a gain for that Rating Category group, EOHHS may cap the EOHHS share of such gain at $0.

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.

7. EOHHS shall sum the final amounts of the Contractor's shares resulting from **Sections 4.5.C.1-6** above. This sum shall equal the Contractor's final amount of the Contractor's share of the gain or loss from the Contract Wide Risk Sharing Arrangement.

D. CBHI Services Risk Sharing Arrangement

For RC I Child and RC II Child, the Contractor and EOHHS shall share risk for CBHI Services, as well as Behavioral Health screens and CANS screens as specified by EOHHS, in accordance with the following provisions:

1. Overall Approach

   All payments shall be calculated and determined by EOHHS based on the adjusted expenditures for CBHI Services, Behavioral Health screens, and CANs screens and the CBHI Add-On to the Risk Adjusted Capitation Rates.

2. EOHHS will first determine the amount paid to the Contractor by EOHHS for CBHI Services, Behavioral Health screens, and CANS screens for the Contract Year by multiplying the following:

   a. The CBHI Add-On to the applicable Risk Adjusted Capitation Rates, which shall be determined by EOHHS and provided to the Contactor in **Appendix D, Exhibit 1**; by

   b. The number of Member months determined by EOHHS using the Enrollee Days determined through the reconciliation set forth in **Section 4.4**.

3. EOHHS will then determine the Contractor's adjusted expenditures for CBHI Services, Behavioral Health screens, and CANS screens for the Contract Year by multiplying the following:

   a. The number of service units provided by the Contractor with respect to CBHI Services, Behavioral Health screens, and CANS screens, which shall be determined by the claims

data submitted in the report described in **Section 4.5.B** and by Encounter Data submitted by the Contractor; by

b. As appropriate, the applicable rate for each of the CBHI Services, Behavioral Health screens, and CANS screens as established by EOHHS or the applicable case rate established by EOHHS in accordance with **Section 2.7.A.3.f.**

4. If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.D.2** above, is greater than or less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.D.3** above, then the Contractor shall be considered to have experienced a gain or loss, respectively, with respect to CBHI Services for the Contract Year, and EOHHS and the Contractor shall share such gain or loss, respectively, in accordance with **Appendix D, Exhibit 3**.

E. ABA Services Risk Sharing Arrangement

For RCs I Child and II Child, the Contractor and EOHHS shall share risk for Applied Behavioral Analysis (ABA Services) in accordance with the following provisions:

1. Overall Approach

All payments shall be calculated and determined by EOHHS based on the adjusted expenditures for ABA Services and the ABA Add-On to the Risk Adjusted Capitation Rates.

2. EOHHS will first determine the amount paid to the Contractor by EOHHS for ABA Services for the Contract Year by multiplying the following:

a. The ABA Add-On to the applicable Risk Adjusted Capitation Rates, which shall be determined by EOHHS and provided to the Contactor in **Appendix D, Exhibit 1;** by

b. The number of Member months determined by EOHHS by using the Enrollee Days determined by the reconciliation set forth in **Section 4.4**.

3. EOHHS will then determine the Contractor's adjusted expenditures for ABA Services for the Contract Year by multiplying the following:

a. The number of service units provided by the Contractor with respect to ABA Services, as set forth in 101 CMR 358.03, which shall be determined by the claims data submitted in the report described in **Section 4.5.B** and by Encounter Data submitted by the Contractor;

b. The applicable rate for the ABA Services established by EOHHS in accordance with **Section 2.7.D.7.f**.

4. If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.E.2** above, is greater than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.E.2** above, then the Contractor shall be considered to have

experienced a gain with respect to ABA Services for the Contract Year. EOHHS and the Contractor shall share such gain in accordance with **Appendix D, Exhibit 3.**

F. Hepatitis C Virus (HCV) Component Risk Sharing Arrangement

For all Regions and Rating Categories the Contractor and EOHHS shall share risk for the cost of providing HCV Drugs, as defined in Section 1, in accordance with the following provisions:

1. Overall Approach

All payments shall be calculated and determined by EOHHS based on the Contractor's actual HCV drug expenditures relating to all Enrollees, and the HCV Component of the Risk Adjusted Capitation Rate Payment aggregated across all Regions and Rating Categories.

2. HCV Component of the Risk Adjusted Capitation Rate Payment

EOHHS shall first determine the HCV Component of the Risk Adjusted Capitation Rate Payment for the applicable Contract Year in aggregate across all Regions and Rating Categories.

a. For each quarter, EOHHS shall determine the HCV Component of the Risk Adjusted Capitation Rate Payment for that quarter by multiplying the following:

1) The HCV Component of the Risk Adjusted Capitation Rate for the applicable quarter, as determined by EOHHS, which shall equal the HCV Component of the Base Capitation Rates set forth in Appendix D, Exhibit 1, multiplied by the quarterly risk adjustment factor for each Region and Rating Category, by

2) The number of Member Months for the quarter for each Region and Rating Category, using the Enrollee Days determined by the reconciliation set forth in Section 4.4; and

3) Summing the HCV Component of the Risk Adjusted Capitation Rate Payments calculated above across all Regions and Rating Categories.

b. The Contractor's HCV Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall equal the sum of the quarterly HCV Component of the Risk Adjusted Capitation Payments paid by EOHHS for the Contract Year as determined by EOHHS, as calculated in **Section 4.5.F.2.a** above.

3. Actual medical expenditures for HCV Drugs

EOHHS shall then determine the Contractor's actual medical expenditures for HCV Drugs in aggregate across all Regions and Rating Categories for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.B** above, and may verify such data in a manner it determines appropriate.

4. If the Contractor's actual Medical Expenditures for HCV Drugs, as determined by EOHHS in accordance with the above provisions, in the aggregate is greater than or less than the HCV Component of the Risk Adjusted Capitation Rate Payment for the Contract Year in aggregate,

the Contractor and EOHHS shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Appendix D**, **Exhibit 3**.

G. Non-HCV High-Cost Drug Component Risk Sharing Arrangement

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for the cost of providing Non-HCV High Cost Drugs, as defined below, in accordance with the following provisions:

1. Overall Approach

All payments shall be calculated and determined by EOHHS based on the Contractor's actual Non-HCV High Cost Drug expenditures relating to all Enrollees, and the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment aggregated across all Regions and Rating Categories.

2. Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment

EOHHS shall first determine the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the applicable Contract Year in aggregate across all Regions and Rating Categories.

a. For each quarter, EOHHS shall determine the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for that quarter by multiplying the following:

1) The Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate for the applicable quarter, as determined by EOHHS, which shall equal the Non-HCV High Cost Drug Component of the Base Capitation Rates set forth in **Appendix D, Exhibit 1,** multiplied by the quarterly risk adjustment factor for each Region and Rating Category, by

2) The number of Member Months for the quarter for each Region and Rating Category, using the Enrollee Days determined by the reconciliation set forth in **Section 4.4**; and

3) Summing the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payments calculated above across all Regions and Rating Categories.

b. The Contractor's Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall equal the sum of the quarterly non-HCV High Cost Drug Component of the Risk Adjusted Capitation Payments paid by EOHHS for the Contract Year as determined by EOHHS, as calculated in **Section 4.5.F.2.a** above.

3. Actual medical expenditures for Non-HCV High Cost Drugs

EOHHS shall then determine the Contractor's actual expenditures for Non-HCV High Cost Drugs in aggregate across all Regions and Rating Categories for the applicable Contract Year

based on the data submitted by the Contractor, as described in **Section 4.5.B** above, and may verify such data in a manner it determines appropriate.

4. If the Contractor's actual Medical Expenditures for Non-HCV High Cost Drugs, as determined by EOHHS in accordance with the above provisions, in the aggregate is greater than or less than the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year in aggregate, the Contractor and EOHHS shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Appendix D**, **Exhibit 3**.

H. [Reserved]

I. SUD Services Risk Sharing Arrangement

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for SUD Services in accordance with the following provisions:

1. Overall Approach

   All payments shall be calculated and determined by EOHHS based on the Contractor's actual SUD Services expenditures relating to all Enrollees and the SUD Add-On to the Risk Adjusted Capitation Rates.

2. EOHHS will first determine the amount paid to the Contractor by EOHHS for SUD Services for the Contract Year by multiplying the following:

   a. The SUD Add-On to the applicable Risk Adjusted Capitation Rates, which shall be determined by EOHHS and provided to the Contactor in **Appendix D, Exhibit 1**; by

   b. The number of Member months determined by EOHHS using the Enrollee Days determined through the reconciliation set forth in **Section 4.4**.

3. EOHHS will then determine the Contractor's actual medical expenditures for SUD Services in aggregate across all Regions and Rating Categories for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.B** above, and may verify such data in a manner it determines appropriate.

4. If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.I.2** above, is greater than or less than the Contractor's actual medical expenditures, as determined by the calculation described in **Section 4.5.I.3** above, then the Contractor shall be considered to have experienced a gain or loss, respectively, with respect to SUD Services for the Contract Year, and EOHHS and the Contractor shall share such gain or loss, respectively, in accordance with **Appendix D, Exhibit 3.**

J. [Reserved]

K. [Reserved]

Section 4.6 Performance Incentive Arrangements and Withhold

A. Performance Incentive Arrangements

1. EOHHS may establish annual performance standards and financial sanctions or incentive arrangements for the Contractor related to its performance of Contractor responsibilities. EOHHS shall determine whether the Contractor has met, exceeded, or fallen below any and all such performance standards and shall provide the Contractor with written notice of such determinations.

2. In no case shall total payments to the Contractor exceed 105% of the Contractor-specific Capitation payments, as determined by EOHHS.

3. All Performance Incentive arrangements shall meet the following requirements:

   a. Performance Incentives shall be for a fixed period of time, which shall be described in the specific Performance Incentive;

   b. No Performance Incentive shall be renewed automatically;

   c. All Performance Incentives shall be made available to both public and private contractors;

   d. No Performance Incentive shall be conditioned on intergovernmental transfer agreements;

   e. All Performance Incentives 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

   f. The Contractor's performance under any Performance Incentive shall be measured during the Contract Year in which the Performance Incentive is effective.

B. Performance Incentive Withhold

1. Each month EOHHS may withhold a percentage of the Contractor's Estimated Capitation Payment, not to exceed 5%, for Performance Incentives.

2. All Performance Incentive withholds shall meet the following requirements:

   a. Performance Incentive withholds shall be for a fixed period of time, which shall be described in the specific Performance Incentive;

   b. No Performance Incentive withhold shall be renewed automatically;

c. All Performance Incentive withholds shall be made available to both public and private contractors;

d. No Performance Incentive withhold shall be conditioned on intergovernmental transfer agreements;

e. 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

f. The Contractor's performance under any Performance Incentive withhold shall be measured during the Contract Year in which the Performance Incentive withhold is effective.

Section 4.7 Reinsurance

The Contractor may purchase reinsurance from a company authorized to do business in Massachusetts, to cover medical costs that exceed a threshold per Enrollee for all rating categories for the duration of the Contract period. Such reinsurance policy is not required and is at the Contractor's discretion.

Section 4.8 Option to Audit

EOHHS, or its authorized agent, may perform an audit to verify any claims data submitted by the Contractor. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed or that EOHHS shall recover from the Contractor. If an audit is not conducted, EOHHS shall, within a reasonable time after receipt of claims data from the Contractor and in accordance with any applicable timeframe described in the Contract, reimburse to the Contractor or recover from the Contractor as provided in the reconciliation processes described in this **Section 4** or the process described in accordance **Section 6.4**, as appropriate.

SECTION 5. ADDITIONAL TERMS AND CONDITIONS

Section 5.1 Administration

A. Notification of Administrative Changes

The Contractor shall notify EOHHS 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 manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a Material Subcontractor. The Contractor shall notify EOHHS 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.

B. Assignment or Transfer

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.

C. Independent Contractors

The Contractor, its employees, 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 EOHHS or the Commonwealth of Massachusetts.

D. Subrogation

Subject to EOHHS's lien and third party recovery rights, the Contractor shall:

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

2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder, pursuant to the Benefit Coordination Plan to be implemented under the provisions of **Section 2.19**. The Contractor may ask the Enrollee:

a. To take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and to take no action prejudicing the rights and interest of the Contractor hereunder; and

b. To notify the Contractor hereunder and to authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

E. Advance Directives

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 must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

F. Compliance with Certification, Program Integrity and Prohibited Affiliation Requirements

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

G. Prohibited Affiliations and Exclusion of Entities

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, 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.

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).

H. Physician Incentive Plans

The Contractor:

1. May, in its discretion, operate a physician incentive plan only if:

a. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

b. 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; and

c. The applicable stop-loss protection, Enrollee survey, and disclosure requirements of 42 CFR Part 417 are met;

2. Shall comply, and assure its 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, which, subject to federal approval, shall be consistent with the format required by the Centers for Medicare and Medicaid Services for Medicare contracts;

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 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; and

4. Shall implement Provider Performance Incentives (or pay-for-performance), as appropriate, to promote compliance with guidelines and other QI initiatives, in accordance with the above stipulations and **Section 2.13.D**.

I. National Provider Identifier (NPI)

The Contractor shall require each Provider providing MCO 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.

J. Provider-Enrollee Communications

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 his or her patient, for the following:

a. The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. Any information the Enrollee needs in order to decide among all relevant treatment options;

c. The risks, benefits, and consequences of treatment or non-treatment; and

d. The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2. Notwithstanding the provisions of **Section 5.1.J.1** 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 must furnish information about any service the Contractor does not cover due to moral or religious grounds as follows.

a. To EOHHS:

1) With its application for a Medicaid contract; and

2) At least 60 days prior to adopting the policy during the term of the Contract.

b. To Potential Enrollees, via enrollment/Marketing materials, at least 30 days prior to adopting the policy during the term of the Contract.

c. 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.

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.

K. No Enrollee Liability for Payment

1. The Contractor shall:

a. Ensure, in accordance with 42 USC §1396 u-2(b)(6) and 42 CFR 438.106, that an Enrollee will not be held liable:

1) For debts of the Contractor, in the event of the Contractor's insolvency;

2) For services (other than Excluded Services) provided to the Enrollee in the event that:

a) The Contractor fails to receive payment from EOHHS for such services; or

b) A Provider fails to receive payment from EOHHS or the Contractor for such services, including but not limited to payments that are in excess of the amount the enrollee would owe if the Contractor covered the service directly.

b. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in **Section 5.1.K.2** below.

c. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any charge permitted under **Section 5.1.K.2**.

d. 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.

e. Ensure Provider compliance with all Enrollee payment restrictions, including balance billing and co-payment provisions, and develop and implement a plan to sanction any Provider that does not comply with such provisions.

f. Return to the Enrollee the amount of any liability inappropriately imposed on and paid by the Enrollee

2. Notwithstanding any other requirement in this Contract, the Contractor shall charge Enrollees pharmacy copayments in the same amounts as the pharmacy copayments established by EOHHS for Members not enrolled in managed care. See 130 CMR 450.130.

L. Enrollee Rights

1. The Contractor must have written policies regarding Enrollee rights and must comply with any applicable federal and state laws that pertain to Enrollee rights;

2. The Contractor must ensure that its staff and affiliated Providers take those rights into account when furnishing services to Enrollees;

3. Enrollee rights shall include:

a. The right to receive the information required pursuant to this Contract;

b. The right to be treated with respect and with due consideration for his or her dignity and privacy;

c. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

d. The right to receive a second opinion on a medical procedure and have the Contractor pay for such second opinion consultation visit;

e. The right to participate in decisions regarding his or her health care, including the right to refuse treatment;

f. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

g. The right to freely exercise his or her rights without adversely affecting the way the Contractor and its Providers treat the Enrollee;

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

i. The right to be furnished MCO Covered Services in accordance with this Contract.

M. Coverage of Emergency, Screening and Post-Stabilization Services

The Contractor shall comply, and assure its Providers and Material Subcontractors comply with all state and federal requirements governing Emergency, Screening and Post-Stabilization services including, but not limited to, 42 USC § 1395dd, 42 USC § 1396u-2(b)(2).

N. Restraint and Seclusion

The Contractor shall require any Provider that is a psychiatric residential treatment facility providing inpatient psychiatric services to individuals under age 21, to comply with all requirements relating to restraint and seclusion as set forth in 42 CFR 441.151 subpart D, and 42 CFR 483 subpart G and in DMH's Human Rights and Restraint and Seclusion Policy **Appendix G**.

O. Disclosure Requirements

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.

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.

a. Ownership and Control

Upon any renewal or extension of this Contract and within 35 days of any change in ownership, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.104 regarding ownership and control, both with respect to the Contractor and Material Subcontractors.

b. Business Transactions

Within 35 days of a written request by EOHHS, or the U.S. Department of Health and Human Services, the Contractor shall furnish full and complete information to EOHHS, or the U.S. Department of Health and Human Services, as required by 42 CFR 455.105 regarding business transactions.

c. Criminal Convictions

Upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.106 regarding persons convicted of crimes.

d. Other Disclosures

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; and

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;

3. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Section 5.1.O.2.a-c** above, the Contractor shall fully and accurately complete the EOHHS form developed for such purpose, the current version of which is attached hereto as **Appendix L**. EOHHS may update or replace **Appendix L** without the need for a Contract amendment.

4. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 5.1.O** or in response to the information contained in the Contractor's disclosures under this **Section 5.1.O**. In addition, the Contractor shall not be entitled to payment for any MassHealth services for which EOHHS determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238, et seq. to impose sanctions.

Section 5.2 Privacy and Security of Personal Data and HIPAA Compliance

A. Covered Entities

EOHHS and the Contractor acknowledge that they are covered entities, as defined at 45 CFR 160.103.

B. Statutory Requirements

The Contractor shall comply with all applicable requirements regarding the privacy, security, use and disclosure of personal data (including protected health information, such as medical records and any

other health and enrollment information), including, but not limited to, requirements set forth in M.G.L. c. 66A, 42 CFR 431, Subpart F, and 45 CFR Parts 160, 162 and 164.

C. Contractor's Compliance with HIPAA

The Contractor represents and warrants that:

1. It shall conform to the requirements of all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations;

2. It shall work cooperatively with EOHHS on all activities related to ongoing compliance with HIPAA requirements, as directed by EOHHS; and

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.

D. Research Data

The Contractor shall seek and obtain EOHHS prior written authorization for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

E. Requesting Member-Level Data or Reports

If the Contractor wishes to receive member-level data or reports that may be available from EOHHS under the Contract, the Contractor may be required to submit a request to EOHHS and execute a Data Use Agreement containing any representations and/or privacy and security requirements applicable to the data and/or report(s) that EOHHS may determine necessary or appropriate.

Section 5.3 General Terms and Conditions

A. Compliance with Laws

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.

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.

3. The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with any requirement of federal law or regulation.

B. Loss of Licensure/Accreditation

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 approvals, the Contractor shall report such loss to EOHHS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.5** herein.

C. Indemnification

The Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, or any of its subcontractors provided that:

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

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

D. Prohibition Against Discrimination

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 must give the affected providers written notice of the reasons for its decision. This Section shall not be construed to prohibit the Contractor from including 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.

2. If a complaint 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 complaint or claim.

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.

E. Information Sharing

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.

F. Other Contracts

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 not serve as another MCO model under the MassHealth MCO program. The Contractor shall also 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.

G. Intellectual Property

1. With respect to intellectual property rights described in this **Section 6.3**, the following terms have the following meaning:

   a. Contractor Property means all intellectual property developed by the Contractor, including all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor in connection with such Intellectual property.

   b. EOHHS Property means all intellectual property developed by or for EOHHS that is not Contractor Property, including all copyright, patent, trade secret, trademark and other intellectual property rights created by or for EOHHS (including the work product of

EOHHS subcontractors and vendors) related to the creation, management or implementation of EOHHS' ACO program. For the sake of clarity, it is understood and agreed by EOHHS and Contractor that the work product of EOHHS subcontractors and vendors does not include Contractor's work product.

2. Contractor Property

a. The Contractor will retain all right, title and interest in all Contractor Property. EOHHS acknowledges that its possession or use of Contractor Property will not transfer to it any title to such intellectual property.

b. The Contractor shall have all the rights incidents and obligations of ownership with respect to the Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties.

c. Nothing in this Section 5.3.G shall limit the Contractor's obligations set forth in this Contract, including but not limited to the obligations set forth in Section 2.

d. Nothing in this Agreement shall be construed as a waiver by EOHHS of any rights and obligations under Federal Regulations, including, but not limited to, 45 CFR Section 75.322.

3. EOHHS Property and Data

a. EOHHS will retain all right, title and interest in and to all EOHHS Property. The Contractor acknowledges that its possession or use of EOHHS Property will not transfer to it any title to such intellectual property.

b. EOHHS shall have all the rights, incidents and obligations of ownership with respect to EOHHS Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties.

c. The Contractor shall not disseminate, reproduce, display or publish any EOHHS Property except in accordance with the terms and pursuant to its obligations under this Contract without the prior written consent of EOHHS.

d. All data acquired by the Contractor from EOHHS or from others on behalf of EOHHS in the performance of this Contract (including personal data, if any) remain the property of EOHHS. The Contractor agrees to provide EOHHS free and full access at all reasonable time to all such data, regardless of whether the data is stored by the Contractor or, where applicable, its subcontractors.

e. The Contractor shall not use EOHHS-owned data, materials and documents, before or after termination or expiration of this Contract, except as required for the performance of the services hereunder.

f. The Contractor shall return to EOHHS promptly, but in any event no later than one week after EOHHS's request, EOHHS-owned or Commonwealth-owned data, and EOHHS Property. If such return is not feasible, the Contractor shall, at EOHHS's direction, destroy all EOHHS- or Commonwealth-owned data and/or EOHHS Property.

H. Counterparts

This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

I. Entire Contract

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.N**. 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.

J. No Third Party Enforcement

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.

K. Intermediate Sanctions

1. In addition to Termination under **Section 5.5**, EOHHS may, in its sole discretion, impose any or all of the sanctions in **Section 5.3.K.2** upon any of the events below; provided, however, that EOHHS shall only impose those sanctions it determines to be reasonable and appropriate for the specific violation(s) identified. Sanctions may be imposed in accordance with this Section if the Contractor:

    a. Fails substantially to provide Medically Necessary items and services required to be provided under this Contract or under law to Enrollees;

    b. Imposes co-payments, premiums or other charges on Enrollees in excess of any permitted under this Contract;

    c. Discriminates among Enrollees on the basis of health status or need for health care services, including termination of enrollment or refusal to reenroll an Enrollee, except as permitted under **Section 2.4.D**, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services;

d. Misrepresents or falsifies information provided to CMS or EOHHS;

e. Misrepresents or falsifies information provided to Enrollees, Members, or Providers;

f. Fails to comply with requirements regarding physician incentive plans;

g. Fails to comply with requirements regarding Provider-Enrollee communications;

h. Fails to comply with applicable federal or state statutory or regulatory requirements related to this Contract;

i. Violates restrictions or other requirements regarding Marketing;

j. Fails to comply with Quality Improvement Goal requirements consistent with **Appendix B;**

k. Fails to comply with any corrective action plan required by EOHHS;

l. Fails to comply with financial solvency requirements as set forth in **Section 2.15**;

m. Fails to comply with any other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations;

n. Fails to comply with the False Claims provision of the Deficit Reduction Act of 2005;

o. Submits contract management reports, Care Management reports, or Quality Improvement Goal reports that are either late or missing a significant amount of information or data;

p. Fails to meet any of the standards for data submission described in this Contract, including accuracy, completeness, timeliness, and other standards for Encounter Data described in **Section 2.14 and Appendix E**. Sanctions for such failure are further described in **Section 5.3.K.5** below;

q. Fails to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as set forth in **Section 2.6.B.4.c**; or

r. Fails to comply with any other requirements of this Contract.

2. Such sanctions may include, but are not limited to:

a. Civil money penalties in accordance with 42 CFR 438.704 and **Section 5.3.K.4** below;

b. Financial measures EOHHS determines are appropriate to address the violation;

c. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396u-2(e)(2)(B) and 42 CFR 438.706;

d. Notifying the affected Enrollees of their right to disenroll;

e. Suspension of enrollment (including assignment of Enrollees);

f. Suspension of payment to the Contractor for Enrollees enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

g. Disenrollment of Enrollees;

h. Limitation of the Contractor's coverage area;

i. Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance; and

j. Such other measures as EOHHS determines appropriate to address the violation.

3. For any Contractor responsibilities for which the Contractor utilizes a Material Subcontractor, if EOHHS identifies any deficiency in the Contractor's performance under the Contract for which the Contractor has not successfully implemented an approved corrective action plan in accordance with **Section 5.3.L**, EOHHS may:

   a. Require the Contractor to subcontract with a Material Subcontractor deemed satisfactory by EOHHS; or

   b. Otherwise require the Contractor to alter the manner or method in which the Contractor performs such Contractor responsibility.

4. Civil money penalties shall be administered in accordance with 42 CFR 438.704 as follows:

   a. The limit is $25,000 for each determination under the following subsections of **Section 5.3.K.1** above:

      1) K.1.a. (failure to provide Medically Necessary items and services);

      2) K.1.e. (misrepresentation or false statement to an Enrollee, Member, or Provider);

      3) K.1.f. (failure to comply with requirements regarding physician incentive plans); or

      4) K.1.i. (violates restrictions or other requirements regarding Marketing).

b. The limit is $100,000 for each determination under the following subsections of **Section 5.3.K.1**. above:

1) K.1.c. (discrimination); or

2) K.1.d. (misrepresentation or false statements to CMS or EOHHS).

c. The limit is $15,000 for each Enrollee EOHHS determines was terminated or not re-enrolled because of a discriminatory practice under **Section 5.3.K.1.c** above (with an overall limit of $100,000 under **Section 5.3.K.4.b** above).

d. The limit is $25,000 or double the amount of the excess charges, whichever is greater, for each determination under **Section 5.3.K.1.b** above.

5. Encounter Data and other Related Data Capitation Payment Deduction

a. For each month where the Contractor has not met data submission standards, including those for Encounter Data, as described **in Section 2.14, Appendix E**, and elsewhere in this Contract, EOHHS shall apply a Capitation Payment deduction as follows:

1) EOHHS shall deduct 2% from the Contractor's Capitation Payment for one month;

2) Once Contractor has corrected a month's data submission, in EOHHS' determination, EOHHS shall pay the Contractor the amount of the deduction applied for such month;

3) If EOHHS subsequently detects additional deficiencies in such corrected data submission, EOHHS may apply the deduction again to a subsequent month's Capitation Payment;

4) EOHHS shall administer such deductions so that EOHHS shall at no time have applied more than five such deductions. Deductions that are paid back as described in **Section 5.3.K.4.e.2** above shall not count towards such five deduction limit; and

5) Notwithstanding the deductions described in this Section, EOHHS may take corrective action for any failure by Contractor to comply with the data submission requirements of this Contract;

b. Beginning with risk sharing arrangements for Contract Year 2019, if the Contractor does not meet Encounter Data and other data or documentation submission deadlines for risk sharing arrangements as specified in **Section 4.5.B.5**, EOHHS may apply a Capitation Payment deduction equal to $400,000.00, if EOHHS chooses to incorporate such Encounter Data and other data and documentation into risk corridor settlement

for that particular Contract Year pursuant to **Section 4.5.B.5**. EOHHS will not impose such Capitation Payment deduction if EOHHS chooses not to incorporate such Encounter Data and other data and documentation into risk corridor settlement for that particular Contract Year pursuant to **Section 4.5.B.5**.

6. For each quarter where the Contractor has not met Contract requirements to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as set forth in **Section 2.6.B.4.c,** EOHHS shall apply a Capitation Payment deduction as follows:

    a. Such deduction shall be in the amount of rebates lost to EOHHS during such quarter as the result of Contractor's failure to meet such requirements;

    b. Notwithstanding the deduction described in this Section, EOHHS may take corrective action for a failure by the Contractor to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as specified in this Contract, including those requirements set forth in **Section 2.6.B.4.c**.

7. For each instance where the Contractor has failed to submit on time its Financial Encounter Validation Report (also known as the FR-40) as set forth in Appendix A, EOHHS may apply a Capitation Payment deduction as follows:

    a. EOHHS may deduct $500.00 for each business day the Financial Encounter Validation Report is late from the Contractor's next Capitation Payment, unless:

        1) the Contractor has requested an extension at least three business days prior to the report's due date, including with its request the reason for the needed extension and an action plan and timeline for when the Contractor is able to submit such report; and

        2) EOHHS has granted the Contractor's request

    b. If EOHHS grants the Contractor's extension request, EOHHS may deduct $500.00 for each business day the Contractor's Financial Encounter Validation report is late past the new deadline EOHHS granted under the Contractor's extension request from the Contractor's next Capitation Payment.

8. The intermediate sanctions provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

9. Denial of Payment Sanction

    In accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e), EOHHS shall deny payments under this Contract to the Contractor for New Enrollees if CMS denies payment to EOHHS for the same New Enrollees in the following situations:

a. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.3.K.1.a-f** of this Contract is affirmed on review pursuant to 42 CFR 438.730(d).

b. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.3.K.1.a-f** of this Contract is not timely contested by the Contractor under 42 CFR 438.730(c).

For the purposes of this **Section 5.3.K.9**, New Enrollee shall be defined as an Enrollee that applies for enrollment after the Effective Date of this Sanction (the date determined in accordance with 42 CFR 438.730(f)).

10. Before imposing any of the intermediate sanctions specified in this **Section 5.3.K**, EOHHS shall give the Contractor written notice that explains the basis and nature of the sanctions not less than 14 calendar days before imposing such sanction.

11. If the Contractor does not meet the lower bound of a utilization target set forth in **Section 2.6.B.4.e** for the Contract Year as described in **Section 2.6.B.4.e.3**, EOHHS shall apply a Capitation Payment deduction as follows:

    a. Such deduction shall be in the amount of rebates lost to EOHHS for the Contract Year as a result of the Contractor's failure to meet such requirement; provided, however, that EOHHS may calculate such amount at an individual utilization target level and shall then arrive at a final Capitation Payment deduction amount or final amount of payment to the Contractor by EOHHS (in accordance with **Section 4.3.G**) by calculating in the aggregate across all utilization targets all instances where the Contractor did not meet the lower bound of such utilization targets and where the Contractor exceeded the higher bound of such utilization targets. Such final aggregate calculation may result in a payment to the Contractor or a Capitation Payment deduction. EOHHS shall provide the Contractor with a report showing such calculation at the aggregate level.

    b. Notwithstanding the deduction described in this Section, EOHHS may take corrective action for a failure by the Contractor to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as specified in this Contract, including those requirements set forth in **Section 2.6.B.4.e.**

L. Corrective Action Plan

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 shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall promptly and diligently implement the corrective action plan as approved by EOHHS.

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 may subject the Contractor to termination of the Contract by EOHHS or other Intermediate Sanctions as described in **Section 5.3.K**.

M. Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

N. Administrative Procedures Not Covered

EOHHS may, from time-to-time, issue memoranda clarifying, elaborating upon, explaining or otherwise relating to Contract administration and other management matters.

O. Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void and any such invalidity shall not affect the validity of the remainder of this Contract. Moreover, the Contractor shall comply with any such applicable state or federal law or regulation.

P. Conflict of Interest

Neither the Contractor nor any Material Subcontractor shall, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual or other business interest in any entity performing health plan enrollment functions for EOHHS, the CSC Enrollment Vendor and subcontractor(s) if any).

Q. Insurance for Contractor's Employees

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.

2. The Contractor shall offer health insurance to its employees sufficient to ensure that it is not obligated to provide a share payment under Chapter 58.

R. Waiver

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.

Section 5.4 Record Retention, Inspection, and Audit

The Contractor shall cause the administrative and medical records maintained by the Contractor and its subcontractors, including but not limited to, 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 subcontractors, including financial provisions of such Provider Contracts and 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 subcontractors.

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 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.

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.

Section 5.5 Termination of Contract

A. Termination without Prior Notice

EOHHS may terminate this Contract immediately and without prior written notice upon any of the events below. EOHHS shall provide written notice to the Contractor upon such termination.

1. The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

2. The Contractor's admission in writing that it is unable to pay its debts as they mature;

3. The Contractor's assignment for the benefit of creditors;

4. Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceedings;

5. Commencement of an involuntary proceeding against the Contractor or subcontractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law which is not dismissed within sixty days;

6. The Contractor incurs loss of any of the following: (1) licensure at any of the Contractor's facilities; (2) state approval of the Contractor; or (3) NCQA accreditation;

7. Cessation in whole or in part of state or federal funding for this Contract, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases; or

8. The Contractor is non-compliant with **Section 5.1.G**. and the Secretary as permitted under federal law, directs EOHHS to terminate, or does not permit EOHHS to extend, renew, or otherwise continue this Contract.

B. Termination with Prior Notice

1. EOHHS may terminate this Contract upon breach by of the Contractor of any duty or obligation hereunder which breach continues unremedied for 30 days after written notice thereof by EOHHS.

2. EOHHS may terminate this Contract after written notice thereof to the Contractor in the event the Contractor fails to accept any Capitation Rate established by EOHHS.

3. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708 in accordance with **Section 5.5.E.** of this Contract.

4. EOHHS may terminate this Contract if EOHHS determines that state or federal health care reform initiatives or state or federal health care cost containment initiatives make termination of the Contract necessary or advisable as determined by EOHHS.

5. EOHHS may terminate this Contract immediately after written notice in accordance with **Section 5.8.A**.

6. The Contractor may terminate this Contract upon a material breach by EOHHS of a duty or obligation in **Section 4 or 5** of this Contract that creates significant challenges for the Contractor to continue performing under this Contract.

C. Continued Obligations of the Parties

1. In the event of termination, expiration or non-renewal of this Contract, the obligations of the parties hereunder with regard to each Enrollee at the time of such termination, expiration or

non-renewal will continue until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that EOHHS shall exercise best efforts to complete all disenrollment activities within six months from the date of termination, expiration, or non-renewal.

2. In the event that this Contract is terminated, expires, or is not renewed for any reason: (1) EOHHS shall be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive medical care; (2) the Contractor shall promptly return to EOHHS all payments advanced to the Contractor for coverage of Enrollees for periods after the Effective Date of their Disenrollment; and (3) the Contractor shall supply to EOHHS all information necessary for the reimbursement of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims shall be paid to the Contractor accordingly.

3. For termination of the Contract for failure by the Contractor to agree to any Capitation Rate, the Contractor shall accept the lesser of the most recently agreed to Capitation Rates or the new Capitation Rate for each RC as payment in full for MCO Covered Services and all other services required under this Contract delivered to Enrollees until all Enrollees have been disenrolled from the Contractor' Plan; and

4. In the event this Contract is terminated, expires, or is not renewed for any reason or the Contractor no longer serves a Region, the Contractor shall, to facilitate the transition of Enrollees to another MassHealth ACO, MCO or the PCC Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment, Enrollees in care management, Enrollees with active prior authorizations, Enrollees' active drug prescriptions, and Enrollees with relationships with Community Partners. The Contractor shall, if applicable, provide any information to EOHHS regarding Network PCPs for the purposes of smoothly transitioning Enrollees and maintaining continuity of care.

D. Termination Authority

The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

E. Termination Pursuant to 42 CFR 438.708

1. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708

2. If EOHHS terminates this Contract pursuant to its authority under 42 CFR 438.708, EOHHS shall provide the Contractor with a pre-termination hearing in accordance with 42 CFR 438.710 as follows:

   a. EOHHS shall give the Contractor written notice of intent to terminate, the reason for termination, and the time and place of the hearing;

   b. After the hearing, EOHHS shall give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

c. If the decision is affirmed, EOHHS shall give Enrollees notice of the termination and information on their options for receiving MassHealth services following the effective date of termination in accordance with 42 CFR 438.710(b)(2)(iii) and **Section 5.5.C.2.** of this Contract.

3. If EOHHS terminates this Contract, EOHHS and the Contractor shall comply with all Continuing Obligations set forth in **Section 5.5.C.** of this Contract;

F. Removal of one or more of the Contractor's Regions;

In the event that the Contractor no longer serves a Region, all of the requirements in this **Section 5** shall apply.

Section 5.6 Contract Term

This Contract shall be in effect upon execution and end on December 31, 2022, 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 5.5**; provided, however that EOHHS may extend the Contract in any increments up to June 30, 2028, 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.

Section 5.7 Additional Modifications to the Contract Scope

In its sole discretion, EOHHS may, upon written notice to the Contractor:

A. Implement LTSS and expanded substance use disorder services as MCO Covered Services as described in **Section 5.8.D;**

B. Require the Contractor to enhance its policies and procedures for promoting information sharing, certified electronic health record (EHR) systems, and Mass HIway connections, including requiring all PCPs to subscribe to a statewide Event Notification Service once it has been developed by EOHHS;

C. Modify MCO Covered Services including but not limited to services related to substance use disorder services;

D. Require the Contractor to provide pharmacy MCO Covered Services using a uniform formulary specified by EOHHS; and

E. Modify the scope of this Contract to implement other initiatives in its discretion consistent with Delivery System Reform efforts or other MassHealth policy or goals.

Section 5.8 Amendments

A. 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.

B. 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.

C. EOHHS reserves the right to amend the Contract to implement new initiatives or to modify existing initiatives, including enrolling additional Members over the term of the Contract, or reducing current enrollment levels.

1. Possible EOHHS initiatives that could change enrollment include, but are not limited to:

    a. Optional or mandatory enrollment of individuals under age 21 with Medicare or other third-party health insurance;

    b. Optional or mandatory enrollment of individuals age 21 and over with Medicare or other third-party health insurance;

    c. Optional or mandatory enrollment of individuals age 65 and older; and

    d. Optional or mandatory enrollment of individuals who are enrolled in MassHealth's Community First 1115 Demonstration Project, or other 1115 Demonstration Projects.

2. Other possible EOHHS initiatives include but are not limited to:

    a. New EOHHS programs or information technology systems including but not limited to managed care programs and enrollment policies, accountable care organization and other payment reform initiatives;

    b. Expansion of, or changes to, existing EOHHS programs, services, covered benefits, or information technology systems including but not limited to programs related to

managed care programs and enrollment policies, accountable care organizations and other payment reform initiatives, and Emergency Services Programs;

c. Expanding services for which the MCOs are accountable or responsible for arranging and providing, including but not limited to Long-Term Services and Supports;

d. Other programs as specified by EOHHS; and

e. Programs or information technology systems resulting from state or federal legislation, including but not limited to the Patient Protection and Affordable Care Act (ACA) of 2010, and regulations, initiatives, or judicial decisions that may affect in whole or in part EOHHS or the Contract.

D. Other Enrollment Changes

EOHHS shall have the right in its sole discretion to increase or decrease enrollment of Members over the term of the Contract for the following reasons:

1. Changes in EOHHS's methodology by which assignments are made to MassHealth managed care plans or ACOs;

2. Expansion of or changes to existing MassHealth programs, benefit packages, or services;

3. Changes in MassHealth Coverage Types, including the creation or elimination of covered populations; and

4. Programs resulting from state or federal legislation, regulatory initiatives, or judicial decisions that may affect, in whole or in part, any component of this Contract.

E. As needed, EOHHS shall issue a Contract amendment to implement any such initiative or program modification. The Contract amendment shall set forth the terms and conditions for any such initiative or program modification. EOHHS reserves the right to modify the Contract, including but not limited to, Capitation Rates, due to program modifications. Such initiatives and program modifications may include, but shall not be limited to:

1. Adding Long Term Services and Supports as MCO Covered Services beginning on around Contract Year 3.

a. Such services and supports may include services such as the following:

1) Inpatient Chronic Disease & Rehab Hospitals (post-100 days of service)

2) Outpatient Chronic Disease & Rehab Hospitals (post-100 days of service)

3) Nursing Facilities (post-100 days of service)

4) Adult Day Health

5) Adult Foster Care

6) Group Adult Foster Care

7) Day Habilitation

8) Continuous skilled nursing

9) Personal Care Attendant (to include Transitional Living Program)

b. The Contractor may also be required to perform activities associated with the provision of such services, such as

1) Readiness activities prior to Contract Year 3, including but not limited to a showing of:

a) LTSS network sufficiency;

b) Policies and protocols sufficient to meet the assessment, care coordination, and care management needs of beneficiaries in need of LTSS;

c) Readiness to submit LTSS-related reports;

d) Readiness to implement prior authorization, utilization management, and quality improvement for LTSS; and

e) Financial readiness to take on LTSS responsibility; and

f) Readiness to perform assessments to validate LTSS needs at a frequency determined by EOHHS and utilizing formats determined or approved by EOHHS; and

2) Additional responsibilities related to continuity of care, assessment and care planning, and integrated care management.

2. Adding expanded substance use disorder services as MCO Covered Services, which may include but may not be limited to Transitional Support Services and Residential Rehabilitation Services, as directed by EOHHS.

3. Adding requirements related to supporting access, coordination, and continuity of behavioral health care, such as those described in **Section 2.3.B.5.g.**

Section 5.9 Order of Precedence

The Contractor's response specified below is incorporated by reference into this Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

A. This Contract, including any Appendices and amendments hereto;

B. The Request for Responses for Managed Care Organizations issued by EOHHS on December 21, 2016; and

C. The Contractor's Response to the RFR.

Section 5.10 Written Notices

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:

To EOHHS:

Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

To MassHealth:

Director, Compliance and Program Operations, ACO and MCO Programs
Executive Office of Health and Human Services
MassHealth, Payment and Care Delivery Innovation
100 Hancock Street
Quincy, MA 02171

With Copies to:

General Counsel
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02109

To the Contractor:

Nelie Lawless
Vice President, Public Partnerships
Boston Medical Center Health Plan, Inc.
529 Main St., Ste. 500
Charlestown, MA 02129