COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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

CONTRACTOR LEGAL NAME: Commonwealth Care Alliance, Inc. **(and d/b/a):**		**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS	
Legal Address: (W-9, W-4): 30 Winter Street, Boston, MA 02108		**Business Mailing Address:** One Ashburton Place, 5th Fl., Boston, MA 02108	
Contract Manager: Steven Belec	**Phone:** (857)246-8825	**Billing Address (if different):**	
E-Mail: sbelec@commonwealthcare.org	**Fax:** 617-426-3097	**Contract Manager:** Corrinne Altman Moore	**Phone:** 617-573-1601
Contractor Vendor Code: VC6000306320		**E-Mail:** Corrinne.AltmanMoore@mass.gov	**Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**		**MMARS Doc ID(s):** **RFR/Procurement or Other ID Number:** 15LCEHSSCORFA	

☐ **NEW CONTRACT**

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

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

☒ **CONTRACT AMENDMENT**

Enter **Current Contract End Date** *Prior* to Amendment: **December 31, 2024**.

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

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

- ☒ **Amendment to Date, Scope or Budget** (Attach updated scope and budget)
- ☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget)
- ☐ **Contract Employee** (Attach any updates to scope or budget)
- ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

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

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

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

☐ **Maximum Obligation Contract.** Enter total maximum obligation for total duration of this contract (or *new* total if Contract is being amended). $_____.

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

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.) Third Amended and Restated SCO Contract; includes previously executed Amendments 1-8; adds new program integrity provisions, consistent with updated EOHHS policy, updates directed payments for HCBS, BH, and EPTS services, includes provision regarding contacting enrollees with respect to redeterminations, and updates Appendix E, Exhibit 1 Base Capitation Rates.

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

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

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

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

CONTRACT END DATE: Contract performance shall terminate as of **December 31, 2024**, with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:	AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:
X: _____. Date: 09/15/2023	X: _____. Date: 09/18/2023
(Signature and Date Must Be Captured At Time of Signature)	(Signature and Date Must Be Captured At Time of Signature)
Print Name: Courtney Murphy	Print Name: Mike Levine
Print Title: President of Markets, Commonwealth Care Alliance	Print Title: Assistant Secretary for MassHealth

STANDARD CONTRACT FORM INSTRUCTIONS
CONTRACTOR CERTIFICATIONS
COMMONWEALTH TERMS AND CONDITIONS

INSTRUCTIONS

The following Instructions, Contractor Certifications and the applicable Commonwealth Terms and Conditions are incorporated by reference into an executed Standard Contract Form. Instructions are provided to assist with completion of the Standard Contract Form. Additional terms are incorporated by reference. Links to legal citations are to unofficial versions and Departments and Contractors should consult with their legal counsel to ensure compliance with all legal requirements. Please note that not all applicable laws have been cited.

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

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

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

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

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

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

Commonwealth Department Name: Enter the full Department name with the authority to obligate funds encumbered for the Contract.

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

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

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

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

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

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

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

NEW CONTRACTS (Left Side of Form):

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

Procurement or Exception Type: Check the appropriate type of procurement or exception for this Contract. Only one option can be selected. See the Office of the Comptroller Guidance for Vendors Policies (State Finance Law and General Requirements, Acquisition Policy and Fixed Assets) and the Operational Services Division Conducting Best Value Procurements Handbook for details.

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

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

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

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

Contract Employee: Check this option when the Department requires the performance of an Individual Contractor, and when the planned Contract performance with an Individual has been classified using the Employment Status

Form (prior to the Contractor's selection) as work of a Contract Employee and not that of an Independent Contractor.

Other Procurement Exception: Check this option when another procurement exception exists, such as legislation with specific language naming the Contractor as a recipient of a grant or contract, an existing legal obligation, a prohibition or other circumstance that exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements; all other Contract and state finance laws and policies apply. Supporting documentation must be attached to explain and justify the exemption.

CONTRACT AMENDMENT (Right Side of Form)

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

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

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

Amendment Type: Identify the type of Amendment being made. Documentation supporting the updates to performance and budget must be attached.

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

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

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

Other Procurement Exception: Check this option when another procurement exception exists, such as legislation with specific language naming the Contractor as a recipient of a grant or contract; an existing legal obligation; a prohibition or other circumstance that exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Attach Supporting documentation to explain and justify the exemption and whether Contractor selection has been publicly posted.

COMMONWEALTH TERMS AND CONDITIONS

Identify which version of the Commonwealth Terms and Conditions is incorporated by reference into this Contract: the Commonwealth Terms and Conditions (TC), the Commonwealth IT Terms and Conditions (TC-IT), or the Commonwealth Terms and Conditions for Human and Social Services (TC-HHS). The Comptroller Expenditure Classification Handbook identifies the applicable Commonwealth Terms and Conditions based upon the object code for the contract.

COMPENSATION

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

PROMPT PAY DISCOUNTS

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

STANDARD CONTRACT FORM INSTRUCTIONS
CONTRACTOR CERTIFICATIONS
COMMONWEALTH TERMS AND CONDITIONS

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE

Enter a brief description of the Contract performance, project name or other identifying information for the Contract to specifically identify the Contract performance, match the Contract with attachments, determine the appropriate expenditure code (as listed in the Expenditure Classification Handbook) or to identify or clarify important information related to the Contract such as the Fiscal Year(s) of performance (ex. "FY2021" or "FY2021-23"). Identify settlements or other exceptions and attach more detailed justification and supporting documents. Enter "Multi-Department Use" if other Departments can access the procurement. For Amendments, identify the purpose and what items are being amended. Merely stating "see attached" or referencing attachments without a narrative description of performance is insufficient.

ANTICIPATED START DATE

The Department and Contractor must certify when obligations under this Contract/Amendment may be incurred. Option 1 is the default option when performance may begin as of the Effective Date (latest signature date and any required approvals). If the parties want a new Contract or renewal to begin as of the upcoming fiscal year then list the fiscal year(s) (ex. "FY2021" or "FY2021-23") in the Brief Description section. Performance starts and encumbrances reflect the default Effective Date (if no FY is listed) or the later FY start date (if a FY is listed). Use Option 2 only when the Contract will be signed well in advance of the start date and identify a specific future start date. Do not use Option 2 for a fiscal year start unless it is certain that the Contract will be signed prior to the fiscal year. Option 3 is used in lieu of the Settlement and Release Form when the Contract/Amendment is signed late, and obligations are incurred by the Contractor prior to the Effective Date, which the Department has either requested, accepted, or deemed legally eligible for reimbursement, and the Contract includes supporting documents justifying the performance or proof of eligibility and approximate costs. Any obligations incurred outside the scope of the Effective Date under any Option listed, even if the incorrect Option is selected, shall be automatically deemed a settlement included under the terms of the Contract and upon payment to the Contractor will release the Commonwealth from further obligations for the identified performance. All settlement payments require justification and must be under the same encumbrance and object codes as the Contract payments. Performance dates are subject to M.G.L. c. 4, § 9.

CONTRACT END DATE

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

CONTRACTOR AUTHORIZED SIGNATORIES FOR EXECUTION

See Comptroller policies entitled "Department Head Signature Authorization" and "Contractor Authorized Signatory Listing" for guidance.

Authorizing Signature for Contractor/Date: The Authorized Contractor Signatory must sign and enter the date the Contract is signed. See section above under "Anticipated Contract Start Date." **Rubber stamps are not acceptable**. Acceptance of payment by the Contractor shall waive any right of the Contractor to claim the Contract/Amendment is not valid and the Contractor may not void the Contract**.** Proof of Contractor signature authorization on a **Contractor Authorized Signatory Listing** may berequired by the Department if not already on file See Contract and ISA Execution after the COVID-19 State of Emergency.

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

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

Department Name/Title: Legibly enter Authorized Signatory's name and title**.**

CONTRACTOR CERTIFICATIONS AND LEGAL REFERENCES

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

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

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

Laws and Regulations Prohibiting Discrimination and Human Trafficking. Contractors acknowledge and certify as a condition of this Contract that they are responsible for complying fully with all state and federal laws prohibiting

discrimination, human trafficking, and forced labor, including but not limited to M.G.L. c. 265 §§ 49-57.

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

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

Public Records and Access. The Contractor shall provide full access to records related to performance and compliance to the Department and officials listed under Executive Order 195 and M.G.L. c. 11, §12 for six (6) years beginning on the first day after the final payment under this Contract or such longer period as necessary for the resolution of any litigation, claim, negotiation, audit or other inquiry involving this Contract. Access to view Contractor records related to any breach or allegation of fraud, waste and/or abuse may not be denied and Contractor can not claim confidentiality or trade secret protections solely for viewing but not retaining documents. Routine Contract performance compliance reports or documents related to any alleged breach or allegation of non-compliance, fraud, waste, abuse or collusion may be provided electronically and shall be provided at Contractor's own expense. Reasonable costs for copies of non-routine Contract related records shall not exceed the rates for public records under 950 CMR 32.00.

Debarment. The Contractor certifies that neither it nor any of its subcontractors are currently debarred or suspended by the federal or state government under any law or regulation including Executive Order 147; M.G.L. c. 29, § 29F; M.G.L. c. 30, § 39R; M.G.L. c. 149 §§ 27C, 44C and 148B; and M.G.L. c. 152, § 25C.

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

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

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

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

Tax Law Compliance. The Contractor certifies under the pains and penalties of perjury: (1) tax compliance with federal tax laws; (2) tax compliance with state tax laws including, but not limited to, M.G.L. c. 62C, § 49A, reporting of employees and contractors, withholding and remitting of tax withholdings and child support; and (3) Contractor is in good standing with respect to all state taxes and returns due, reporting of employees and contractors under M.G.L. c. 62E, withholding and remitting child support including M.G.L. c. 119A, § 12, TIR 05-11, New Independent Contractor Provisions and applicable TIRs.

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

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

Protection of Commonwealth Data, Personal Data and Information. The Contractor certifies that all steps will be taken to ensure the security and

confidentiality of all Commonwealth data for which the Contractor becomes a holder, either as part of performance or inadvertently during performance, with special attention to restricting access, use and disbursement of personal data and information under M.G.L. c. 93H and c. 66A and other applicable state and federal privacy requirements. The Contractor shall comply with M.G.L. c. 93I for the proper disposal of all paper and electronic media, backups or systems containing personal data and information. The Contractor shall also ensure that any personal data or information transmitted electronically or through a portable device is properly encrypted using (at a minimum) the Commonwealth's "Cryptographic Management Standard" set forth in the Enterprise Information Security Policies and Standards published by the Executive Office for Technology, Services and Security (EOTSS), or a comparable Standard prescribed by the Department. Contractors with access to credit card or banking information of Commonwealth customers certify that the Contractor is PCI compliant in accordance with the Payment Card Industry Council Standards, and shall provide confirmation of compliance during the Contract. The Contractor shall immediately notify the Department in the event of any security breach, including the unauthorized access, disbursement, use or disposal of personal data or information and, in the event of a security breach, the Contractor shall cooperate fully with the Commonwealth and provide access to any information necessary for the Commonwealth to respond to the security breach and shall be fully responsible for any damages associated with the Contractor's breach including, but not limited to, damages under M.G.L. c. 214, § 3B.

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

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

Employer Requirements. Contractors that are employers certify compliance with applicable state and federal employment laws and regulations, including but not limited to prevailing wage laws at M.G.L. c. 149, §§ 26-27D (public construction work); M.G.L. c. 149, § 27F (use of trucks, vehicles and other equipment to perform public works functions); M.G.L. c. 149, § 27G (moving office furniture and fixtures); M.G.L. c. 149, § 27H (cleaning state office buildings or buildings leased by the state); M.G.L. c. 6C, § 44 (MassDOT relocation of utilities or utility facility; M.G.L. c. 7, § 22 (contracts for meat products and clothing and apparel); M.G.L. c. 71, § 7A (transportation of students to public schools); Chapter 195 of the Acts of 2014 (MA Convention Center Authority security guard services); minimum wage and overtime law and regulations (M.G.L. c. 151 and 454 CMR 27.00); child labor laws (M.G.L. c. 149, §§ 56-105); all payment of wages, payroll and timekeeping records, earned sick time, meal breaks, domestic violence leave, temporary worker rights, domestic worker rights and anti-retaliation laws at M.G.L. c. 149 (Labor and Industries); M.G.L. c. 151A (unemployment insurance and contributions); M.G.L. c. 152 (workers compensation and insurance); M.G.L. c. 150A (Labor Relations); M.G.L. c. 153 (liability for injuries); 29 U.S.C. c. 8 (Federal Fair Labor Standards); 29 U.S.C. c. 28 (Federal Family and Medical Leave Act); M.G.L. c. 6, § 171A (applicant criminal record information); M.G.L. c. 149, § 105A (MA Equal Pay Act); and M.G.L. c. 175M (Paid Family Medical Leave Act).

Federal And State Laws And Regulations Prohibiting Discrimination. Contractors certify compliance with applicable state and federal anti-discrimination laws, including but not limited to the Federal Equal Employment (EEO) Laws; the Americans with Disabilities Act; 42 U.S.C § 12101, et seq., the Rehabilitation Act, 29 U.S.C. § 794; 29 U.S.C. § 701; 29 U.S.C. § 623; 42 U.S.C. c. 45; (Federal Fair Housing Act); M.G. L. c. 151B (Unlawful Discrimination); M.G.L. c. 151E (Business Discrimination); the Public Accommodations Law M.G.L. c. 272, § 92A; M.G.L. c. 272, §§ 98 and 98A, Massachusetts Constitution Article CXIV and M.G.L. c. 93, § 103; 47 USC § 255 (Telecommunication Act; M.G.L. c. 149, § 105D, M.G.L. c. 151C, M.G.L. c. 272, §§ 92A, 98 and 98A, and M.G.L. c. 111, § 199A, and Massachusetts Disability-Based Non-Discrimination Standards For Executive Branch Entities, and related Standards and Guidance, authorized under Massachusetts Executive Order or any disability-based protection arising from state or federal law or precedent. See also MCAD and MCAD links and resources.

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

Limitation of Liability. Contracts may not use the following limitation of liability language unless approved by legal staff at the Office of the Comptroller (CTR) or Operational Services Division (OSD), and it may not be used if a Department is utilizing the Commonwealth IT Terms and Conditions. The term "other damages" in Section 11 of the Commonwealth Terms and Conditions, "Indemnification," shall include, but shall not be limited to, the reasonable costs the Commonwealth incurs to repair, return, replace or seek cover (purchase comparable substitute commodities and services) under a Contract. "Other damages" shall not include damages to the Commonwealth as a result of third party claims, provided, that this in no way limits the Commonwealth's right of recovery for personal injury or property damages or patent and copyright infringement under Section 11 or the Commonwealth's ability to join the contractor as a third party defendant. Further, the term "other damages" shall not include, and in no event shall the contractor be liable for, damages for the Commonwealth's use of contractor provided products or services, loss of Commonwealth records, or data (or other intangible property), loss of use of equipment, lost revenue, lost savings or lost profits of the Commonwealth. In no event shall "other damages" exceed the greater of $100,000, or two times the value of the product or service (as defined in the Contract scope of work) that is the subject of the claim. Section 11 sets forth the Contractor's entire liability under a Contract. Nothing in this section shall limit the Commonwealth's ability to negotiate higher limitations of liability in a particular Contract, provided that any such limitation must specifically reference Section 11 of the Commonwealth Terms and Conditions. In the event the limitation of liability conflicts with accounting standards which mandate that there can be no cap of damages, the limitation shall be considered waived for that audit engagement. The terms in this Clarification may not be modified.

Northern Ireland Certification. Pursuant to M.G.L. c. 7, § 22C, for state agencies, state authorities, the state House of Representatives or the state Senate, by signing this Contract the Contractor certifies that it does not employ ten or more employees in an office or other facility in Northern Ireland or if the Contractor employs ten or more employees in an office or other facility located in Northern Ireland the Contractor certifies that it does not discriminate in employment, compensation, or the terms, conditions and privileges of employment on account of religious or political belief, and certifies that it promotes religious tolerance within the work place, and the eradication of any manifestations of religious and other illegal discrimination; and the Contractor is not engaged in the manufacture, distribution or sale of firearms, munitions, including rubber or plastic bullets, tear gas, armored vehicles or military aircraft for use or deployment in any activity in Northern Ireland.

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

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

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

EXECUTIVE ORDERS

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

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

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

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

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

Executive Orders 523, 565, and 592. Executive Order 523 (Establishing the Massachusetts Small Business Purchasing Program.). Executive Order 565 (Reaffirming and Expanding the Massachusetts Supplier Diversity Program). Executive Order 592 (Advancing Workforce Diversity, Inclusion, Equal Opportunity, Non-Discrimination, and Affirmative Action). All programs, activities, and services provided, performed, licensed, chartered, funded, regulated, or contracted for by the state shall be conducted without unlawful discrimination based on race, color, age, gender, ethnicity, sexual orientation, gender identity or expression, religion, creed, ancestry, national origin, disability, veteran's status (including Vietnam-era veterans), or background. The Contractor and any subcontractors may not engage in discriminatory employment practices. The Contractor certifies compliance with applicable federal and state laws, rules, and regulations governing fair labor and employment practices. The Contractor also commits to purchase supplies and services from certified minority, women, veteran, service-disabled veteran, LGBT or disability-owned businesses, small businesses, or businesses owned by socially or economically disadvantaged persons; and Contractor commits to comply with any Applicable Department contractual requirements pertaining to the employment of persons with disabilities pursuant to M.G.L. c. 7 § 61(s). These provisions shall be enforced through the contracting Department, OSD, and/or the Massachusetts Commission Against Discrimination. Any breach shall be regarded as a material breach of the contract that may subject the contractor to appropriate sanctions.

MASSHEALTH SENIOR CARE OPTIONS

THIRD AMENDED AND RESTATED CONTRACT

FOR SENIOR CARE ORGANIZATIONS

BY AND BETWEEN

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

COMMONWEALTH CARE ALLIANCE, INC.

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This Third Amended and Restated Contract is between the Commonwealth of Massachusetts, acting by and through the MassHealth Office of Long Term Services and Supports of the Executive Office of Health and Human Services (EOHHS), and Commonwealth Care Alliance, Inc. (the Contractor). The Contractor's principal place of business is: 30 Winter Street, Boston, MA 02108.

WHEREAS, EOHHS oversees 11 state agencies and is the single state agency of 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 USC §1396 et seq.), and other applicable laws and waivers;

WHEREAS, the Contractor is in the business of providing medical services and EOHHS desired to purchase such services from the Contractor;

WHEREAS, EOHHS and the Contractor entered into the Contract, effective January 1, 2016; EOHHS and the Contractor amended and restated the Contract effective January 19, 2018, with various amendments thereafter (First Amended and Restated); and EOHHS and the Contractor amended and restated the Contract effective February 28, 2019, with various amendments thereafter (Second Amended and Restated);

WHEREAS, in accordance with Section 5.10 of the Contract, EOHHS and the Contractor desire to amend and restate the Contract effective upon execution; and

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

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.

Adult Community Crisis Stabilization (ACCS) - ACCS is a community-based program that serves a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides 24-hour, short-term, staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and treatment include the capacity to provide induction onto and bridging for medications for the treatment of opioid use disorder (MOUD and withdrawal management for opioid use disorders (OUD) as clinically indicated. The ACCS program is an integrated part of the CBHC model.

Adult Mobile Crisis Intervention (AMCI) (formerly known as Emergency Services Program (ESP)) - AMCI provides adult community-based Behavioral Health crisis assessment, intervention, stabilization and follow-up for up to three days. AMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences), and provided via Telehealth to individuals age 21 and older when requested by the member or directed by the 24/7 BH Help Line and clinically appropriate. AMCIs operate ACCS programs with a preference for co-location of services. AMCI services must have capacity to accept adults voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

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

1. the failure to provide Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.6**;
2. the denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;
3. the reduction, suspension, or termination of a previously authorized 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:

a. failure to follow prior authorization procedures;

b. failure to follow referral rules;

c. failure to file a timely claim;

5. the failure to act within the timeframes in **Section 2.4.A.15** for making authorization decisions
6. the denial of an Enrollee's request to dispute a financial liability;
7. the failure to act within the timeframes in **Section 2.8.D** for reviewing an Internal

Appeal and issuing a decision; and

8. an adverse decision on a determination (as defined in 42 CFR § 422.561), to the extent not otherwise included in items (1)-(7).

Aging Services Access Point (ASAP) – an entity organized under Massachusetts General Law (M.G.L.) c.19A §4B that contracts with the Executive Office of Elder Affairs to manage the Home Care Program in Massachusetts.

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.

Appeal – An Enrollee's request for formal review of an action of the Contractor in accordance with **Section 2.8** of the Contract. An Appeal includes an integrated appeal as defined in 42 CFR § 422.561.

Appeal Representative - any individual that the Contractor can document has been authorized by the Enrollee in writing to act on the Enrollee's behalf with respect to all aspects of a Grievance or Appeal (whether internal or external). The Contractor 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. The Enrollee must execute such a standing authorization in writing according to the Contractor's procedures. The Enrollee may revoke such a standing authorization at any time. 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.

Base Capitation Rate – a fixed monthly fee paid prospectively by EOHHS to the Contractor for each Enrollee for all Covered Services actually and properly delivered to the Enrollees in accordance with and subject to the provisions of this Contract and all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended, prior to the application of any risk adjustment.

Behavioral Health Supports for Justice Involved Individuals (BH-JI) – BH- JI Supports involve a range of functions that assist MassHealth Members who are justice involved, either currently incarcerated or detained in a correctional facility, recently released from a correctional facility, or are under the supervision of the Massachusetts Probation Service or Massachusetts Parole Board, in navigating and successfully engaging with health care services, with an emphasis on behavioral health services. BH-JI Supports include in-reach and re-entry supports for individuals releasing from correctional facilities. When directed by EOHHS, the community supports for Enrollees post-release will be provided by the Contractor through Community Support Program Services for Individuals with Justice Involvement (CSP-JI).

Centers for Medicare & Medicaid Services (CMS) - the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.

Centralized Enrollee Record (CER) - centralized and comprehensive documentation, containing information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions. See **Section 2.4.A.8-10** of the Contract for more information about the contents of the Centralized Enrollee Record.

Chronically Homeless – individuals who meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. A "Clean Claim" includes a claim with errors originating in EOHHS's claim system. A "Clean Claim" does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Community Behavioral Health Center (CBHC) - A comprehensive community behavioral health center offering crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. CBHCs include an Adult Mobile Crisis Intervention (AMCI) and Adult Community Crisis Stabilization (ACCS) program.

Complaint- An Enrollee's formal or informal, oral or written, expression of grievance or dissatisfaction with any aspect of the Contractor's provision of care or customer service.

Complex Care Need - any condition or situation that demonstrates the Enrollee's need for expert coordination of multiple services (see **Section 2.4.A.4** of the Contract), including, but not limited to: clinical eligibility for institutional long-term care; and medical illness, psychiatric illness, or cognitive impairment that requires skilled nursing to manage essential unskilled services and care.

Comprehensive Assessment - A tool prescribed by EOHHS in Appendix M to be used by the Contractor to document the physical, cognitive, behavioral and emotional functioning of a MassHealth member, including activities of daily living and instrumental activities of daily living, formal and informal supports, and need for services.

Consumer – a MassHealth Member, aged 65 or older, or the spouse, sibling, child, or unpaid Primary Caregiver of a MassHealth Member who is aged 65 or older.

Continuing Services – 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 participation agreement that EOHHS has with a Contractor, setting forth the terms and conditions pursuant to which an organization may participate in the MassHealth Senior Care Options Program.

Contract Management Team - a group of EOHHS and CMS representatives responsible for the management functions outlined in **Section 3.1** of the Contract.

Contractor – any entity located in the United States that is approved by EOHHS to be a Senior Care Organization and that enters into a Contract to meet the purposes specified in this Contract, including serving as a Fully Integrated Dual Eligible Special Needs Plan, as defined in 42 CFR 422.2, for eligible Enrollees.

Contract Year (CY) - a twelve-month period commencing January 1, and ending December 31, unless otherwise specified by EOHHS.

Covered Services - those services listed in **Appendix A** of the Contract delivered in accordance with **Sections 2.4** and **2.6** of the Contract. For the avoidance of doubt, Covered Services shall not include any items or services for which payment is prohibited pursuant to 42 U.S.C. § 1396b(i)(16) and 42 U.S.C. § 1396b(i)(17).

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

Department of Mental Health (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.

Discharge Planning - the evaluation of an Enrollee's health care and social support needs, including long term care, mental health or substance abuse service needs, in order to arrange for appropriate care after discharge from an institutional level of care to another level of care.

Dual Eligible – an adult aged 65 or older, who is eligible for and enrolled in Medicare Parts A and B and eligible for and enrolled in MassHealth Standard coverage. This includes Qualified Medicare Beneficiaries with full Medicaid (QMB Plus) and Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) aged 65 or older and with MassHealth Standard coverage.

Eligible Individual – a MassHealth Member enrolled in MassHealth Standard and satisfying the criteria set forth in 130 CMR 508.008(A).

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

Emergency Condition (also known as Emergency Care) - when an Enrollee, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. An Emergency Condition may not be limited on the basis of lists of diagnoses or symptoms.

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 I.

Enrollee – a MassHealth Member eligible to enroll in SCO under 130 CMR 508.008(a) who voluntarily enrolls with a Contractor. A MassHealth member is not enrolled until the enrollment transaction is processed via Medicaid Management Information System (MMIS).

Enrollee Information – information about the Contractor for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.5.E**, and an Enrollee handbook that meets the requirements of **Section 2.10.B.7**, and an identification card.

Emergency Service Programs (ESP) - Until otherwise notified by EOHHS, 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. In addition to contracted ESPs, ESP Encounter services may also be provided by outpatient hospital emergency departments as further directed by EOHHS. When notified by EOHHS, Community Behavioral Health Centers will be providing comparable services, including Adult Mobile Crisis Intervention encounters, to Enrollees.

Enrollee Services Representative - an employee of the Contractor who assists Enrollees with questions and concerns.

Executive Office of Elder Affairs (EOEA) - the Secretariat that administers the Massachusetts Home Care Program, Title III, and social and nutrition services under the Older Americans Act, and fulfills advocacy, planning, and policy functions on behalf of the seniors in Massachusetts.

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 and other applicable laws and waivers.

Fiscal Intermediary (FI) – an entity contracting with EOHHS to perform functions that support an Enrollee's employment of PCAs, such as withholding, filing, and payment of federal and state taxes and purchase of worker's compensation insurance (see 130 CMR 422.419), as well as related administrative tasks, including but not limited to issuing PCA checks.

Frail Elder Home and Community Based Services Waiver (Frail Elder Waiver or FEW) – A waiver of federal requirements granted to the Commonwealth, by the U.S. Department of Health and Human Services under 42 U.S.C. 1396n(c), that allows EOHHS to pay for home and community-based services for certain MassHealth members who meet MassHealth criteria for Nursing Facility services but continue to reside in the community and agree to receive a waiver service. The term "Frail Elder Waiver" as used in this contract shall refer to the content of the waiver, as may be updated from time to time as approved by CMS.

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, but are not limited to: 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, but are not limited to, improperly obtaining prescriptions for controlled substances and card sharing.

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) – a managed care plan defined in 42 CFR 422.2 as a dual eligible special needs plan -

(1) That provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract under section 1903(m) of the Act with the applicable State;

(2) Whose capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year;

(3) That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and

(4) That employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.

Functional Status – using the Comprehensive Assessment tool prescribed by MassHealth, measurement of the ability of individuals to perform Activities of Daily Living (ADLs) (for example, mobility, transfers, bathing, dressing, toileting, eating, and personal hygiene) and Instrumental Activities of Daily Living (IADLs) (for example, meal preparation, laundry, and grocery shopping).

Geriatric Model of Care - an interdisciplinary approach to provide assessment, prevention, treatment, and other interventions that minimize disability, to promote positive health behaviors, and to maintain health status and function for Enrollees.

Geriatric Support Services Coordinator (GSSC) - an employee of an ASAP who meets the qualifications as defined by EOEA to deliver the services listed in **Section 2.4.A.5** of the Contract.

Grievance – any expression of dissatisfaction by an Enrollee or Appeal Representative about any action or inaction by the Contractor other than an Adverse Action. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of the Contractor, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievances include an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision. Grievances include integrated grievances, as defined in 42 CFR § 422.561.

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

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

Incident Report – a written report concerning an allegation of abuse, neglect, or exploitation of an Enrollee that the Contractor must submit to EOHHS pursuant to **Section 2.9.C.4.i** of this Contract.

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

Individualized Plan of Care (IPC) - a detailed written description of the scope, frequency, type, amount, and duration, of all Covered Services to be provided by the Contractor to the Enrollee as described in **Section 2.4.A.2** of this Contract.

Initial Assessment – A comprehensive assessment of an Enrollee that includes: (1) an evaluation of clinical status, Functional Status, nutritional status, and physical well-being; (2) the medical history of the Enrollee, including relevant family members and illnesses; (3) screenings for mental-health status and tobacco, alcohol and drug use; and (4) an assessment of the Enrollee's need for long term-services and supports, including the availability of informal support; (5) abuse, neglect, and exploitation of the Enrollee (or the Enrollee's risk of suffering

abuse, neglect, and exploitation); (6) the Enrollee's housing and environmental safety risks; (7) the Enrollee's risk of falling; and (8) The Enrollee's ability to manage medications). EOHHS may prescribe the Initial Assessment tool.

Justice Involvement – Enrollees with Justice Involvement shall be those individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.

Long-Term Services and Supports (LTSS) – The services and supports set forth in **Appendix A-2**. These services 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.

Long Term Services and Supports Third Party Administrator (LTSS TPA) – an organization designated by EOHHS to deliver a variety of administrative services to EOHSS to support the administration of the MassHealth long term services and supports programs, including program integrity, claims services, utilization management, quality benchmarking and management, electronic visit verification, and program analytics and reporting.

MassHealth - the medical assistance and benefit programs administered by the Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act (42 USC 1396), M.G.L. c. 118E, and other applicable laws and regulations (Medicaid).

MassHealth Member - for this Contract, a person who is age 65 or over, enrolled in MassHealth, and eligible for MassHealth Standard.

MassHealth Standard - a MassHealth coverage type that offers a full range of Medicaid health benefits to eligible MassHealth Members.

Medicare - Title XVIII of the Social Security Act, federal health insurance program for people age 65 and older, certain younger disabled people, and people with kidney failure. Medicare Part A provides coverage of inpatient hospital services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

Medicare Advantage - the Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at Part C, and 42 CFR §422.

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.

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 SCO Covered Services including, but not limited to, behavioral health, claims processing, Care Management, Utilization Management, or pharmacy benefits, including specialty pharmacy providers.

Network Provider – see Provider, defined herein.

Nursing Home Certifiable (NHC) - the determination that an Enrollee residing in the community has been found to meet the MassHealth medical eligibility criteria for payment for nursing facility care (see 130 CMR 456).

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 related to Senior Care Options (may also be referred to as My Ombudsman). Ombudsman staff fulfill both individual and systemic advocacy roles.

Ongoing Assessment - a re-evaluation of an Enrollee's health status conducted in accordance with **Section 2.4.A.11** of the Contract. An Ongoing Assessment for an Enrollee identified as having Complex Care Needs must be conducted in person by a Registered Nurse. EOHHS may prescribe the Ongoing Assessment tool.

Opt-In Enrollment – enrollment in a SCO plan initiated by an Eligible Individual.

Opt Out – a process by which an Eligible Individual or his/her Authorized Representative chooses not to be enrolled with the Contractor via Passive Enrollment. An Eligible Individual may Opt Out at any time before the effective date of his or her Passive Enrollment.

Other Provider Preventable Condition (OPPC) – a condition that meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 CFR 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 CFR 447.26(b) and consist of the following:
    a. Wrong surgical or other invasive procedure performed on a patient;
    b. Surgical or other invasive procedure performed on the wrong body part;
    c. Surgical or other invasive procedure performed on the wrong patient;

For each of a. through c., above, the term "surgical or other invasive procedure" is defined in CMS Medicare guidance on NCDs.

2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as Additional OPPCs.

Outreach - marketing, including the use of promotional materials, produced in any medium, targeted to Potential Enrollees to promote the Contractor's program and the use of notification forms and materials to communicate with current Enrollees.

Passive Enrollee – An individual selected for enrollment with the Contractor through the Passive Enrollment process.

Passive Enrollment – An Enrollment process through which an Eligible Individual is enrolled by EOHHS (or its vendor) with a Contractor following a minimum 60-day advance notification period during which the Eligible Individual may elect to make a different enrollment decision (including Opting-Out or enrolling with a different Senior Care Organization).

Personal Care Attendant (PCA) – a person who meets the requirements described in 130 CMR 422.411(A)(1) who is hired by the Enrollee (or a representative of the Enrollee) who provides physical assistance to the Consumer with activities of daily living (as described in 130 CMR 422.410 (A)) or instrumental activities of daily living (as described in 130 CMR 422.410(B)).

Personal Care Management Agency (PCM Agency) – a public or private agency under contract with the Contractor to provide PCM Services to an Enrollee in accordance with 130 CMR 422.000.

Personal Care Management Services (PCM Services) – services provided by a PCM Agency to an Enrollee, including, but not limited to, those services identified in 130 CMR 422.419(A).

Potential Enrollee - a MassHealth Member who may voluntarily elect to enroll in the Senior Care Options Program, but is not yet an Enrollee.

Prevalent Languages – As determined by EOHHS, those languages spoken by a significant percentage of Enrollees in each Region in which the Contractor is contracted by EOHHS to operate. 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 Provider (PCP) - A practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the SCO and responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be nurse practitioners, physician

assistants or physicians who meet the primary care qualifications requirements for Primary Care Providers in **Section 2.5.C.2** of the Contract.

Primary Care Team (PCT) - shall have the meaning ascribed to that term by M.G.L. c. 118E, § 9D(a). To assure effective coordination and delivery of care, the PCT may be enlarged at the discretion of the PCP to include other professional and support disciplines.

Provider - an appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor for the delivery of Covered Services.

Provider Network - the collective group of health care and social support Providers, including but not limited to PCPs, nurses, nurse practitioners, physician assistants, GSSCs, specialty Providers, mental health/substance abuse Providers, community and institutional long term care Providers, pharmacy Providers, and acute hospital and other Providers employed by or under subcontract with the Contractor. (See **Appendix C** of the Contract.)

Provider Preventable Condition (PPC) – as identified by EOHHS through bulletins or other written statements of policy, which may be amended from time to time, a condition that meets the definition of a "Health Care Acquired Condition" or an "Other Provider Preventable Condition" as defined by CMS in federal regulations at 42 CFR 447.26(b).

Quality Management Goals - annual goals negotiated by the Contractor and EOHHS to improve the Contractor's performance under the Contract. Improvement Goals are incorporated into **Section 2.9** of the Contract.

Rate Cells (also known as Rating Categories) (RCs) - the categories used by MassHealth to calculate capitation payments. MassHealth RCs take into account clinical status and whether the Enrollee resides in or outside Greater Boston. The RC system includes payment for institutional and community-based Enrollees. Institutional and community groups are further divided according to the specific clinical needs and status of Enrollees. In addition each rate cell is defined differently for Eligible Enrollees who receive both Medicare Parts A & B and MassHealth and those who only receive MassHealth.

Risk Adjusted Capitation Rate – the Base Capitation Rate as adjusted to reflect acuity of the Enrollees in accordance with **Section 4.1.C** of the Contract.

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

Senior Care Options Program - a program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare- and Medicaid-covered benefits for eligible Massachusetts seniors managed by a SCO using a Geriatric Model of Care.

Senior Care Organization (SCO) – the Contractor.

Serious Reportable Event (SRE) – An event that occurs on premises covered by a hospital's license that results in an adverse patient outcome, is clearly identifiable and measurable,

usually or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital. An SRE is an event that is specified as such by the Department of Public Health (DPH) and identified by EOHHS.

Service Area - the specific geographic area of Massachusetts for which the Contractor agrees to provide Covered Services to all Enrollees residing within that geographic area and who select the Contractor, as approved by CMS and EOHHS . The Contractor's Service Area is described in **Appendix H**.

Service Authorization Request – an Enrollee's request for the provision of a service.

State – the Commonwealth of Massachusetts.

Target MLR –The Target MLR is the Medicaid-only MLR percentage that is consistent with the initial rate development assumptions for the MLR standards as outlined in 42 CFR 438.8 and related policy guidance as described below and in **Section 2.13.Q.1** of this contract.

1. The calculation of the Medicaid-only Target MLR in accordance with 42 CFR 438.8, is as follows:
    a. The numerator of the Target Medicaid-only MLR for each year is the sum of the initial rate development assumptions for Medicaid claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.
    b. The denominator of the Target Medicaid-only MLR for each year is the total Medicaid capitation payment made by EOHHS during the Contract Year.

Urgent Care - medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include Primary Care services or services provided to treat an Emergency Condition.

SECTION 2. CONTRACTOR RESPONSIBILITIES

Through the Senior Care Options Program, EOHHS, in coordination with CMS, offers MassHealth seniors the option of enrolling with a SCO, which consists of a comprehensive network of health and social service Providers. Each SCO will deliver and coordinate all components of Medicare and MassHealth Covered Services for Enrollees.

Section 2.1 Compliance

A. On-Site Readiness Review

Prior to commencing an initial enrollment of MassHealth Members, the Contractor must successfully complete an on-site readiness review, which will include an assessment of the Contractor's ability and capacity to perform satisfactorily in each of the areas set forth in 42 CFR 438.66(d)(4), and demonstrate to EOHHS that it has been designated by CMS as a Medicare Advantage Special Needs Plan for persons dual eligible for Medicare and Medicaid and with Medicare Part D authority for each county or region to be served by the Contractor. Failure on the part of the Contractor to demonstrate this designation or to successfully complete an on-site readiness review will be grounds for contract termination pursuant to **Section 5.7**.

B. Compliance with Applicable Law

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 well as the implementing regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as well as the implementing regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act as amended; the Assisted Suicide Funding Restriction Act of 1997; Medicare Advantage program requirements in Part C and Part D of Title XVIII of the Social Security Act and 42 CFR Part 422; 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. The Contractor shall not impose on an Enrollee an annual dollar limit or aggregate lifetime limit on Behavioral Health Covered Services. The Contractor shall not impose on an enrollee any quantitative treatment limitation, as defined in 42 C.F.R. 438.900, on Behavioral Health Covered Services.

C. Mental Health Parity Law

In accordance with 130 CMR 450.117(J), 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, including subpart K of 42 CFR 438; and guidance; and submit a certification of compliance to EOHHS in accordance with 130 CMR 450.117(J)(1) and any additional instructions provided by EOHHS.

The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits. The Contractor shall not impose on an Enrollee an annual dollar limit or aggregate lifetime limit on Behavioral Health Covered Services. The Contractor shall not impose on an enrollee any quantitative treatment limitation, as defined in 42 C.F.R. 438.900, on Behavioral Health Covered Services.

D. Outpatient Drugs

Pursuant to 42 U.S.C. § 1396b(m)(2)(A)(xiii), covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate required by the agreement entered into under 42 U.S.C. § 1396r–8 as the State is subject to and the State shall collect such rebates from manufacturers. The Contractor shall report to the State, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary.

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.

E. Bulletins Issued by EOHHS

The Contractor shall, to the satisfaction of EOHHS, comply with all applicable bulletins issued by EOHHS.

F. Medicaid and Medicare Coordination and Integration

The Contractor shall employ policies and procedures approved by EOHHS and CMS to coordinate or integrate Member communication materials, enrollment, communications, Grievances and Appeals, and quality improvement as further described in this Contract, including but not limited to **Sections 2.3.F, 2.4, 2.6, 2.8, and 2.9.**

Section 2.2 Contract Management

A. Director of the Contractor's Senior Care Options Program

The Contractor must employ a qualified individual to serve as the Director of its Senior Care Options Program. The Director must be primarily dedicated to the Contractor's program, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program.

B. SCO Director Responsibilities

The Director must act as a liaison between the Contractor, EOHHS and CMS and have responsibilities that include, but are not limited to, the following:

1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the SCO RFR and approved by EOHHS and CMS;
3. Oversee all activities by the Contractor and its Subcontractors, including but not limited to, coordinating with the Contractor's quality management director, medical director, geriatrician, and behavioral health clinician;
4. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least 30 days before the intended effective date of the change;
5. Receive and respond to all inquiries and requests made by EOHHS and CMS, in time frames and formats set by EOHHS and CMS;
6. Meet with representatives of EOHHS or CMS, or both, on a periodic or as-needed basis to resolve issues that arise;
7. Ensure the availability to EOHHS or CMS, upon their request, of those members of the Contractor's staff who have appropriate expertise in each of the operational functions covered under this contract.
8. Attend and participate in director meetings when requested by EOHHS and CMS;
9. Coordinate requests and activities among the Contractor, all Subcontractors, EOHHS, and CMS;
10. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, EOHHS, or CMS; and
11. Ensure that the Contractor maintain written policies and procedures, including, but not limited to, policies regarding Enrollee rights in accordance with 42 CFR 438.100.

C. By January 1, 2023, the Contractor shall operate a Medicare Advantage dual eligible special needs plan for its SCO product under a unique CMS Medicare contract number ("H number"), subject to CMS approval, separate from all other Medicare Advantage contracts offered by the Contractor.

Section 2.3 Enrollment Activities

Enrollment in the Senior Care Options Program is voluntary. For a MassHealth Member to be eligible to enroll in the Senior Care Options Program, the Member must be MassHealth Standard eligible and meet all other eligibility requirements as set forth in 130 CMR 508.008 (A).

Medicare eligibility is not a prerequisite for enrollment in the Senior Care Options Program. MassHealth Members with or without Medicare may enroll in the Senior Care Options Program, provided they meet all eligibility requirements as set forth in 130 CMR 508.008 (A).

Note: An individual enrolled in Medicare but not eligible for MassHealth Standard (i.e. not a Dual Eligible Senior) is not eligible to enroll in the Senior Care Options Program.

A. Opt-in Enrollment

1. The Contractor may submit Opt-In Enrollments to EOHHS on behalf of MassHealth Members eligible for, and seeking to enroll in, the Senior Care Options Program. Prior to submitting such an enrollment to EOHHS, the Contractor shall verify through EOHHS's electronic on-line Eligibility Verification System (EVS) that the MassHealth Member is MassHealth Standard eligible. The Contractor must utilize enrollment forms that are approved by EOHHS and CMS.
2. The Contractor must document Member consent to enroll in the Senior Care Options Program in accordance with all applicable rules and guidance and as further directed by EOHHS. The Contractor may not accept enrollment requests telephonically without verifying member consent by obtaining the member's signature on an enrollment form. The Contractor may use alternative means of consent only for Members who are not able to provide a signature as an accessibility accommodation.
3. The Contractor must maintain records of all such Member consents.

B. Eligibility for SCO

In conducting enrollment activities under this Contract, the Contractor must implement the applicable state and federal enrollment criteria, including but not limited to the criteria set forth in 130 CMR 508.00 et seq. For an individual to be eligible to enroll with the Contractor, the individual must meet the following requirements, as set forth in 130 CMR 508.000 et seq.

1. The individual must:
    a. Be eligible for MassHealth Standard;
    b. Be 65 years of age or older. When and as directed by EOHHS, the Contractor may enroll otherwise eligible Members who:
        1) Have been redetermined eligible for MassHealth Standard pursuant to 130 CMR 519.000 et seq. and,
        2) Are turning 65 years of age during the month in which the SCO enrollment would first be effective; and

c. Live in the Contractor's designated Service Area.

2. The individual must not:

   a. Have access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001;

   b. Be an inpatient in a chronic disease or rehabilitation hospital, or in an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services;

   c. Have presumptive eligibility;

   d. Be subjected to a six-month deductible period under 130 CMR 520.028;

   e. Be enrolled in a home and community-based services waiver other than the Frail Elder Waiver as described in 130 CMR 519.007(B). Otherwise eligible individuals eligible for or participating in the Frail Elder Waiver may be enrolled with the Contractor;

   f. Be a refugee described at 130 CMR 522.002; and

   g. Be diagnosed as having end-stage renal disease (ESRD) for enrollments effective prior to January 1, 2021. For enrollments effective on or after January 1, 2021, an otherwise eligible Member with ESRD may enroll with the Contractor.

C. Aligning MassHealth and Medicare Coverage

Individuals who are otherwise eligible for SCO and who also have Medicare may be enrolled with the Contractor. The Contractor must provide exclusively aligned enrollment for Dual Eligible individuals. The Contractor must conduct enrollments and disenrollments for Dual Eligible individuals to always ensure the individual's MassHealth and Medicare enrollments are aligned and maintained with the same Senior Care Organization. Such individuals may not be enrolled in a Senior Care Organization for either of their Medicare or MassHealth coverage without being also enrolled with that Senior Care Organization for both sets of coverage.

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

D. Enrollment Mechanisms

1. Enrollment in the Senior Care Options Program is voluntary.

2. Opt-In Enrollment

   The Contractor may submit Opt-In Enrollments to EOHHS on behalf of MassHealth Members eligible for, and seeking to enroll in, the Senior Care Options Program. Prior to submitting such an enrollment to EOHHS, the Contractor shall verify through EOHHS's electronic on-line Eligibility Verification System (EVS) that the MassHealth Member is MassHealth Standard eligible. The Contractor must utilize enrollment forms that are approved by EOHHS and CMS and must maintain on file any such forms that have been signed by Enrollees.

3. Passive Enrollment

   a. EOHHS may conduct Passive Enrollment during the term of the Contract. Individuals who Opt Out will not be included in future Passive Enrollments.

   b. The schedule for Passive Enrollment will be determined by EOHHS. EOHHS reserves the right to make changes to the Passive Enrollment schedule at its discretion and at any time.

   c. EOHHS will provide notice to each Passive Enrollee at least 60 days prior to the effective date of his or her enrollment with the Contractor.

   d. EOHHS will accept Opt Out requests from Passive Enrollees prior to the effective date of enrollment.

   e. EOHHS may stop Passive Enrollment in the Contractor's plan at its discretion, and for any reason, including if the Contractor does not comply with this Contract.

   f. EOHHS will monitor Passive Enrollment assignments to all SCO plans and may make adjustments to the volume and spacing of Passive Enrollment periods at its discretion. In exercising this discretion, EOHHS may consider any factor(s) that it deems relevant, including the capacity of the Contractor, and the capacity of the other SCO plans, to accept potential Passive Enrollees.

E. All Enrollments

This **Section 2.3E** applies to all Enrollments, whether Opt-In Enrollments pursuant to **Section 2.3.D.2** or Passive Enrollments pursuant to **Section 2.3.D.3**.

1. Subject to the eligibility requirements set forth I 130 CMR 508.000 et seq. and in **Section 2.3.B** above, the Contractor must accept each Enrollee in the order in which he or she seeks to join the Contractor's plan or is assigned to the Contractor's plan, without restrictions, regardless of his or her income status, physical or mental condition, age, gender, gender identity, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing condition(s), health status or expected health status, or need for health care services, in accordance with federal and State requirements.
2. EOHHS will assign Rate Cells (RCs) upon enrollment, For certain RCs, the Contractor must submit a request, including documentation supporting the requested RC. For additional information on RCs, see **Section. 4**.
3. Except as specified in accordance with **Section 2.3.E.6.** below, enrollments received, approved and processed via the MassHealth Medicaid Management Information System (MMIS) by the last business day of the month will be effective on the first calendar day of the following month.
4. The Contractor will be responsible for providing Covered Services to Enrollees from the effective date of enrollment.
5. The Contractor must have a mechanism for receiving timely information about all enrollments in the Contractor's program, including the effective date of enrollment, from CMS and EOHHS systems.
6. Special Enrollment Periods (SEPs). In the event that a Dual Eligible individual does not

have an available Medicare SEP to allow a change in their Medicare enrollment for an effective date of the first calendar of the following month, the Contractor shall hold the Medicaid enrollment or disenrollment transaction and shall submit it to MMIS no sooner than the first day of the month preceding the next available month in which a change in Medicare enrollment may be effective. The MassHealth and Medicare enrollment effective dates must remain aligned when Medicare's SEP policy prevents a Medicare enrollment change.

7. The Contractor must accept enrollment requests from otherwise eligible Members with end-stage renal disease for effective dates on or after January 1, 2021.

F. Primary Care Providers

1. Selection of a Primary Care Provider

   Upon enrollment, the Contractor must assist the Enrollee to choose a PCP and assist the Enrollee in selecting a new PCP whenever necessary. If the Enrollee has not selected a PCP by the effective date of enrollment, the Contractor must assign the Enrollee a PCP.

2. Termination of a PCP

   When a PCP is terminated from the Contractor's program, the Contractor must make a good faith effort to give written notification of termination of the PCP, within the later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the receipt or issuance of the notice, to each Enrollee who received his or her Primary Care from, or was seen on a regular basis by, the terminated PCP.

G. Initial Assessment

The Contractor must complete an Initial Assessment of the Enrollee within 30 calendar days of the effective date of the Enrollee's enrollment with the Contractor. The Initial Assessment must include:

1. A face-to-face evaluation of the Enrollee's clinical status, Functional Status, nutritional status, and physical well-being;
2. The Enrollee's medical history, including relevant family members and illnesses;
3. A screening of the Enrollee's mental-health status, and tobacco, alcohol and drug use; and
4. An assessment of the Enrollee's need for long term services and supports, including the availability of informal support.
5. An assessment of abuse, neglect, and exploitation of the Enrollee (or the Enrollee's risk of suffering abuse, neglect, and exploitation);
6. An assessment of the Enrollee's housing and environmental safety risks
7. An assessment of the Enrollee's risk of falling; and

8. An assessment of the Enrollee's ability to manage medications.

H. Enrollee Orientation

The Contractor must:

1. Provide an orientation to Enrollees within 30 calendar days of the effective date of enrollment;
2. Make available to family members, significant informal caregivers, and designated representatives, as appropriate, any enrollment and orientation materials upon request;
3. For Enrollees for whom written materials are not appropriate, provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations;
4. Notify its Enrollees:
    a. That written information is available in Prevalent Languages;
    b. That oral interpretation services are available for any language;
    c. How Enrollees can access oral interpretation services; and
    d. How Enrollees can access non-written materials described in **Section 2.3.F.3** above.
5. Ensure that all orientation materials are provided in a manner and format that may be easily understood, including oral interpretation services in all non-English languages when requested. Orientation materials must include the following:
    a. A list of Covered Services;
    b. A Provider Network directory;
    c. A description of the roles of the PCP and PCT and the process by which Enrollees select and change PCPs including the role of the GSSC for enrollees requiring home and community based services;
    d. The Contractor's Evidence of Coverage (see **Appendix B**) including, but not limited to, descriptions of:
        1) Enrollee rights;
        2) An explanation of the Centralized Enrollee Record (CER) and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers (see **Section 2.4.A.8-10**);
        3) How to obtain a copy of the Enrollee's CER;
        4) How to obtain access to specialty, behavioral health, and long term care services;
        5) How to obtain services for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area;

6) Information about advance directives (at a minimum, that required by subpart I of 42 CFR 489), designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desires of the Enrollee;

7) How to obtain assistance from ESRs;

8) How to contact the Ombudsman for assistance in navigating the SCO program and consumer advocacy services;

9) How to file Grievances and Appeals with the Contractor;

10) How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

11) How to obtain assistance with the Medicare and Medicaid Appeals processes through the ESR and Ombudsman; and

12) How to disenroll voluntarily.

e. An explanation of each Enrollee's right to be free from abuse, neglect, and exploitation, and how to report abuse, neglect, and exploitation.

I. Disenrollment

1. Subject to any restrictions imposed by federal or state laws or regulations, including 130 CMR 508.008(D), an Enrollee may initiate disenrollment from the Contractor's program for any reason and at any time.
2. An Enrollee may initiate disenrollment from the Contractor's program by submitting a written request to disenroll either to the State or to the Contractor.

3. The Contractor:

a. Must have a mechanism for receiving timely information about all disenrollments from the Contractor's program, including the effective date of disenrollment, from CMS and EOHHS systems. Disenrollments received and approved by the last business day of the month will be effective on the first calendar day of the following month;

b. Must be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment;

c. May request that an Enrollee be involuntarily disenrolled for the following reasons *only*:

1) Loss of MassHealth eligibility;

2) Remaining out of the Service Area for more than six consecutive months; or

3) If approved in advance by EOHHS, when the Contractor's ability to furnish services to the Enrollee or to other Enrollees is seriously impaired; and

d. *May not* request that an Enrollee be involuntarily disenrolled for any of the following

reasons:

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

2) The Enrollee's utilization of medical services;

3) The Enrollee's diminished mental capacity; or

4) The Enrollee's uncooperative or disruptive behavior (except when the Enrollee's continued enrollment seriously impairs the Contractor's ability to furnish services to the Enrollee or other Enrollees); and

e. Must transfer Enrollee record information to the new Provider upon written request signed by the disenrolled Enrollee; and

f. Must make disenrollment determinations within the timeframe set forth in 42 CFR 438.56(e)(1). In the event that the Contractor fails to make a disenrollment determination within such timeframe, the disenrollment is considered approved.

J. Closing Enrollment

The Contractor shall not discontinue or suspend enrollment for Enrollees for any amount of time without 30 calendar days advance notice and the approval of EOHHS.

K. Transition of Care Policy

The Contractor shall ensure that:

1. Each new Enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for 90 days if that provider is not in the Contractor's network, or until the member is assessed and a plan of care is implemented, whichever is sooner;
2. Each new Enrollee is referred to appropriate Network Providers;
3. For each disenrolling Enrollee, in accordance with federal and state law, the Contractor fully and timely complies with requests for historical utilization data from the Enrollee's new managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, primary care case manager, or primary care case management entity, as those terms are defined in 42 CFR 438.2;
4. For each disenrolling Enrollee, in accordance with federal and state law, the Contractor assists the Enrollee's new provider(s) with obtaining copies of the Enrollee's medical records, as appropriate; and
5. The Contractor implements any other procedures specified by CMS or EOHHS to ensure the Enrollee's continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.

Section 2.4 Care Management and Integration

A. General

1. Service Delivery

The Contractor must authorize, arrange, coordinate and provide all Covered Services for its Enrollees (see Covered Services in **Appendix A**). The Contractor's provision of Covered Services must comply with the federal regulations for the availability of services as provided in 42 CFR 438.206.

2. Individualized Plan of Care (IPC).

a. The Contractor must develop an IPC for each Enrollee. The IPC must:

1) Incorporate the results of the Initial Assessment and specify any changes in providers, services, or medications.

2) Be developed by the PCP or PCT under the direction of the Enrollee (and/or the Enrollee's representative, if applicable), and in consultation with any specialists caring for the Enrollee, in accordance with 42 C.F.R. 438.208(c)(3) and 42 C.F.R. 422.112(a)(6)(iii) and updated periodically to reflect changing needs identified in Ongoing Assessments. For Enrollees who require LTSS, the plan must be developed by a person or persons trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR 441.301(c)(1) and (2). For FEW Enrollees requiring LTSS, the Contractor shall ensure that the IPC is also developed in accordance with the requirements set forth in **Appendix D** of the FEW (found at **Appendix P** of this Contract), entitled Participant-Centered Planning and Service Delivery. In all instances the Enrollee will be at the center of the care planning process.

3) Reflect the Enrollee's preferences and needs. The Contractor will ensure that the Enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process, including the development of the IPC and that the Enrollee receives clear information about:

a) His/her health status, including functional limitations;

b) How family members and social supports can be involved in the care planning as the Enrollee chooses;

c) Self-directed care options and assistance available to self-direct care;

d) Opportunities for educational and vocational activities;

e) Available treatment options, supports and/or alternative courses of care;

f) His or her right to choose (i) Covered Services for which he or she is eligible and (ii) Network Providers to provide such services; and

g) The Enrollee's right to be free from abuse, neglect, and exploitation and how to report abuse, neglect, and exploitation.

4) Specify how services and care will be integrated and coordinated among health care providers, and community and social services providers where relevant to the Enrollee's care;

5) Include, but is not limited to:

a) A summary of the Enrollee's health history;

b) A prioritized list of concerns, goals, and strengths;

c) The plan for addressing concerns or goals;

d) The person(s) responsible for specific interventions; and

e) The due date for each intervention.

b. The Contractor must:

1) Establish and execute policies and procedures that provide mechanisms by which an Enrollee can sign or otherwise convey approval of his or her IPC when it is developed and at the time of subsequent modifications to it;

2) Inform an Enrollee of his or her right to approve the IPC;

3) Provide mechanisms for an Enrollee to sign or otherwise convey approval of the IPC that meet his or her accessibility needs; and

4) Inform 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 IPC.

5) Inform an Enrollee how to contact the Ombudsman.

3. Accepting and Processing Assessment Data

For the purposes of quality management and Rating Category determination, the Contractor must accept, process, and report to EOHHS uniform person-level Enrollee data, based upon an Initial and Ongoing Assessment process that includes ICD-10 diagnosis codes, an assessment as designated by EOHHS, and any other data elements deemed necessary by EOHHS.

4. Assessment and Determination of Complex Care Needs

Upon enrollment, and as appropriate thereafter, the Contractor must perform Initial and Ongoing Assessments. This process will identify all of an Enrollee's needs, and, in particular, the presence of Complex Care Needs. In performing these assessments, the Contractor must also comply with 42 CFR 438.208(c)(2) through (4) and M.G.L. c. 118E, § 9D(h)(3).

5. Geriatric Support Services Coordinator (GSSC)

a. The Contractor must provide a GSSC to members requiring certain long-term services and supports through a contract with one or more of the ASAPs that complies with M.G.L. c. 118E, § 9D. The regions served by the ASAP and the

ASAP's qualification to deliver GSSC services shall be determined by EOEA. If more than one ASAP is operating in the Contractor's Service Area, the Contractor may:

1) Contract with all of the ASAPs; or

2) Contract with a lead ASAP to coordinate all the GSSC work in the Contractor's Service Area.

b. The GSSC is responsible for:

1) All of the activities set forth in M.G.L. c. 118E, § 9D(h)(2), which consist of:

a) Arranging, coordinating and authorizing the provision of LTSS and community long-term care and social support services, based on the Enrollee's needs assessment and IPC and with the agreement of other primary care team members designated by the Contractor;

b) Coordinating non-covered services and providing information regarding other elder services, including, but not limited to, housing;

c) Monitoring the provision and outcomes of community long-term care and support services, according to the enrollee's service plan, and making periodic adjustments to the enrollee's service plan as deemed appropriate by the primary care team;

d) Tracking enrollee transfer from one setting to another; and

e) Scheduling periodic reviews of enrollee care plans and assessment of progress in reaching the goals of an enrollee's care plan.

2) Other care management related activities as may be determined and contracted for by the Contractor.

c. If there is only one ASAP operating in the Contractor's service area and the Contractor identifies any of the following deficiencies in the performance of the ASAP with which it has contracted, the Contractor must follow the procedure in **Section 2.4.A.5.e**.

1) The ASAP does not meet its responsibilities relating to the performance of GSSC functions and GSSC qualifications established by the Contractor;

2) The ASAP does not satisfy clinical or administrative performance standards, based on a performance review evaluation by the Contractor and subsequent failure by the ASAP to correct documented deficiencies; or

3) The ASAP meets its basic responsibilities relating to the performance of GSSC functions and GSSC qualifications established by the Contractor, but is substantially less qualified than other ASAPs.

d. The Contractor and an ASAP may enter into any appropriate reimbursement relationship for GSSC services, such as fee-for-service reimbursement, capitation,

or partial capitation. If the Contractor is unable to execute or maintain a contract with any of the ASAPs operating in its Service Area due to lack of agreement on reimbursement-related issues, the Contractor must collaborate with EOHHS and EOEA to explore all reasonable options for reconciling financial differences, before terminating or failing to initiate a contract. If the Contractor fails to execute a contract with an ASAP operating in its service area, or determines that it must terminate a contract with an ASAP, and that is the only ASAP operating in its service area, the Contractor must follow the procedure in **Section 2.4.A.5.e**. The Contractor will cooperate with EOHHS and the Executive Office of Elder Affairs to ensure any claims submitted by the ASAPs are accepted and processed through a standardized system. The Contractor must ensure GSSC services are not duplicated by other care management functions delivered by the Contractor, Providers or other subcontractors and that care management is only counted once for each member in the Medicaid-only MLR calculation, as that term is defined in **Section 2.13.Q.1**.

e. If the Contractor has identified any of the deficiencies set forth in **Section 2.4.A.5.c**; is unable to execute a contract with an ASAP; or determines that it must terminate a GSSC contract with an ASAP, and that is the only ASAP that operates in the Contractor's Service Area; the Contractor must notify EOHHS in writing, within five business days of the triggering event, with detailed specific findings of fact that indicate the deficiencies. If EOHHS finds that the Contractor's reasons are not substantiated with sufficient findings, EOHHS will develop a corrective action plan for the Contractor that ensures continuation of GSSC services and specifies the actions the Contractor will take.

f. Nothing in this **Section 2.4.A.5** precludes the Contractor from entering into a subcontracting relationship with any ASAP for functions beyond those required by M.G.L. c. 118E § 9D, including, but not limited to:

   1) Providing community-based services, such as homemaker, chore, and respite services;

   2) Performing initial and on-going assessments; and

   3) Conducting risk-assessment and care-planning activities regarding non-medical service needs of Enrollees without Complex Care Needs.

6. Integration and Coordination of Services

   a. The Contractor must ensure effective linkages of clinical and management information systems among all Providers in the Provider Network, including clinical Subcontractors (that is, acute, specialty, behavioral health, and long term care Providers). The Contractor must ensure that the PCP or the PCT integrates and coordinates services including, but not limited to:

      1) An IPC, as described in **Section 2.4.A.2** of this Contract;

      2) Written protocols for generating or receiving referrals and for recording and tracking the results of referrals;

3) Written protocols for providing or arranging for second opinions, whether in or out of the Provider Network;

4) Written protocols for sharing clinical and IPC information, including management of medications;

5) Written protocols for determining conditions and circumstances under which specialty services will be provided appropriately and without undue delay to Enrollees who do not have established Complex Care Needs;

6) Written protocols for obtaining and sharing individual medical and care planning information among the Enrollee's caregivers in the Provider Network, and with CMS and EOHHS for quality management and program evaluation purposes;

7) Coordinating the services the Contractor furnishes to the Enrollee between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stay; and

8) Coordinating services provided by the Contractor with the services:

a) The Enrollee receives from any other managed care entity;

b) The Enrollee receives in fee-for-service Medicaid; and

c) The Enrollee receives from community and social support providers.

b. The Contractor shall ensure that each Enrollee receives the contact information for the person or entity primarily responsible for coordinating the Enrollee's care and services, whether that is the PCP or his or her designee on the PCT.

7. Coordinating Access for Emergency Conditions and Urgent Care Services

The Contractor must ensure linkages among the PCP, the PCT, and any appropriate acute, long term care, or behavioral health Providers to keep all parties informed about utilization of services for Emergency Conditions and Urgent Care. The Contractor may not require advance approval for the following services:

a. Any services for Emergency Conditions;

b. Emergency behavioral health care;

c. Urgent Care sought out of the Service Area;

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

e. Direct-access women's services; and

f. Out-of-area renal dialysis services.

8. Centralized Enrollee Record (CER)

To coordinate care, the Contractor must maintain a single, centralized, comprehensive record that documents the Enrollee's medical, functional, and social status. The Contractor must make appropriate and timely entries describing the care provided,

diagnoses determined, medications prescribed, and treatment plans developed. The organization and documentation included in the CER must meet all applicable professional requirements. The CER must contain the following:

a. Enrollee identifying information;
b. Documentation of each service provided, including the date of service, the name of both the authorizing Provider and the servicing Provider (if different), and how they may be contacted;
c. Multidisciplinary assessments, using the assessment tool designated by EOHHS, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate Provider;
d. Laboratory and radiology reports;
e. Reconciled medication list;
f. Prescribed medications, including dosages and any known drug contraindications;
g. Reports about the involvement of community agencies that are not part of the Provider Network, including any services provided;
h. Documentation of contacts with family members and persons giving informal support, if any;
i. Disenrollment agreement, if applicable;
j. Enrollee's individual advance directives and health care proxy, recorded and maintained in a prominent place;
k. Plan for Emergency Conditions and Urgent Care, including identifying information about any emergency contact persons;
l. Allergies and special dietary needs; and
m. Documentation of Initial and Ongoing Assessments; including verification that an Enrollee has received services for which Providers have billed the Contractor and in accordance with **Section 2.4.A.11.b.iv**.

9. Requirements for CER Information
    a. The Contractor shall, at a minimum, comply with, and require Providers to comply with, all statutory and regulatory requirements applicable to CER Information and other Enrollee medical records. In addition, the CER shall, at a minimum:
        1) Be maintained in a manner that is current, detailed, and organized and that permits effective patient care and quality review;
        2) Include sufficient information to identify the Enrollee, date of encounter and pertinent information which documents the Enrollee's diagnosis;
        3) Describe the appropriateness of the treatment/services, the course and results of the treatment/services; and
        4) Be consistent with current professional standards for providing the treatment/services, as well as systems for accurately documenting the following:

a) Enrollee information;

b) Clinical information;

c) Clinical assessments;

d) Treatment plans;

e) Treatment/services provided;

f) Contacts with Enrollees' family, guardians, or significant others; and

g) Treatment outcomes.

b. The Contractor shall implement systems to ensure that the CER is:

1) Updated in a timely manner by each Provider of care;

2) Available and accessible 24 hours per day, seven days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care Providers for Emergency Conditions and Urgent Care; and

3) Available and accessible to specialty, long term care, and mental health and substance abuse Providers.

c. The Contractor shall provide a copy of the CER at EOHHS' 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 under this Contract. The Contractor shall provide such 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.

10. Confidentiality of CER Information

The Contractor must have and comply with written policies to ensure the confidentiality of CER information. Such policies must include the following:

a. At a minimum, complying with all federal and State legal requirements as they pertain to confidentiality of Enrollee records, including, without limitation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 CFR parts 160 and 164, M.G.L. c. 66A, and, if applicable, M.G.L. c. 123 §36;

b. Informing Enrollees how to obtain a copy of their CER and how to request that it be amended or corrected;

c. Requiring all Subcontractors to abide by the confidentiality protections established by the Contractor;

d. Ensuring that documentation of mental health and substance abuse treatment in the CER includes only documentation of behavioral health assessment, diagnosis, treatment plan, therapeutic outcome or disposition, and any medications prescribed

(psychotherapeutic session notes must not be recorded in the CER);

e. Providing records at the request of EOHHS or CMS, or both, for monitoring the quality of care provided by the Contractor in accordance with federal law (for example, 42 USC 1396a (a) (30)) and conducting performance evaluation activities; and

f. Auditing all access to records to ensure that only authorized individuals have access to information to prevent misuse.

11. Frequency of Assessments

The Contractor must:

a. Complete an Initial Assessment within 30 calendar days of the effective date of enrollment. In the event that the Contractor's initial attempts to contact the Enrollee are unsuccessful, the Contractor shall make subsequent attempts to conduct the initial screening;

b. Ensure that documentation of Initial and Ongoing Assessments contain documentation of assessment of:

1) The Enrollee's clinical status, Functional Status, nutritional status, and physical well-being;

2) The Enrollee's medical history, including relevant family members and illnesses;

3) The Enrollee's mental-health status and tobacco, alcohol and drug use;

4) The Enrollee's need for long term-services and supports, including the availability of informal supports;

5) Any abuse, neglect, and exploitation of the Enrollee (or the Enrollee's risk of suffering abuse, neglect, and exploitation);

6) The Enrollee's housing and environmental safety risks

7) The Enrollee's risk of falling; and

8) The Enrollee's ability to manage medications.

c. Schedule and perform Ongoing Assessments, utilizing an assessment tool approved by EOHHS, of each Enrollee's needs:

1) At least once every six months, or

2) At least quarterly for Enrollees who require Complex Care and it is to be performed by a member of the Enrollee's PCT, or

3) Whenever an Enrollee experiences a major change that is:

a) Not temporary;

b) Impacts more than one area of health status; and

c) Requires interdisciplinary review or revision of the Individualized Plan of Care.

4) The Contractor shall have a process in place to verify Enrollee receipt of services for which Providers have billed the Contractor. This verification of covered services shall be documented in the CER in accordance with **Section 2.4.A.8.n**.

d. In accordance with professional standards, record the results of all assessments in the CER; and

e. In accordance with professional standards, share the results of any identification and assessment of the Enrollee's needs with MassHealth, other managed care entities serving the Enrollee, and the Enrollee's provider network in a timely manner to prevent duplication of those activities.

12. Coordinating Services with Federal, State, and Community Agencies

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

1) Educating Enrollees about the availability of Ombudsman services:

a) On the Contractor's website

b) When Enrollees receive the Enrollee Handbook;

c) At the time of the Initial and Ongoing assessments; and

d) When Enrollee, and their family members and representatives, contact SCO plan staff, including CSRs, with a concern, complaint, Grievance or Appeal;

2) Communicating and cooperating with Ombudsman staff as needed for them to investigate and resolve Enrollee requests for information, issues or concerns related to SCO, including:

a) Designating a staff person as the Contractor's Ombudsman liaison, who shall liaise with the Ombudsman to resolve issues raised by Enrollees;

b) Providing Ombudsman staff with access to records needed to investigate and resolve Enrollee Grievances (with the Enrollee's consent); and

c) Ensuring ongoing commutation and cooperation of the Contractor's staff with Ombudsman staff in working to investigate and resolve Enrollee Grievances, including updates on progress made towards resolution, until such time as the Grievances have been resolved.

b. The Contractor must implement a systematic process for coordinating care and creating linkages for services for its Enrollees with organizations not providing Covered Services including, but not limited to:

1) State agencies (for example, EOEA, the Department of Public Health, the Department of Developmental Services, and the Department of Mental Health);

2) Social service agencies (such as the Councils on Aging) and services (e.g., housing);

3) Consumer, civic, and religious organizations; and

4) Federal agencies (for example, the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).

c. The systematic process and associated linkages must provide for:

1) Sharing information and generating, receiving, and tracking referrals;

2) Obtaining consent from Enrollees to share individual Enrollee medical information where necessary; and

3) Ongoing coordination efforts (for example, regularly scheduled meetings, newsletters, and joint community-based projects).

d. Pursuant to 42 CFR § 438.3(t), the Contractor shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process.

13. The Contractor shall ensure that services are provided to Enrollees with a Department of Mental Health (DMH) affiliation as follows:

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

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

c. Ensure that for all DMH clients, the IPC specifies all Behavioral Health Services as defined in **Appendix A Exhibit 1** required during any acute Behavioral Health Inpatient Services stay, identifies discharge plans and, when appropriate, indicates the need for DMH Community-Based Services or continuing inpatient psychiatric care as part of the IPC.

14. Consumer Participation on Governing and Advisory Boards

The Contractor must obtain Consumer and community input on issues of program management and participant care. At least one Consumer shall serve on the Contractor's governing board. The Contractor must also establish at least one Consumer advisory committee and a process for that committee to provide input to the governing board.

15. Authorization of Services

In accordance with 42 CFR 438.210, the Contractor and its Subcontractors, if applicable, must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services to ensure consistent application of review criteria for authorization decisions. In connection with the processing of such requests, the Contractor shall consult with the requesting Provider when appropriate. These written policies and procedures shall require that:

a. The GSSC shall have all of the responsibilities set forth in **Section 2.4.A.5**;

b. Any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in addressing the Enrollee's medical, behavioral health, or long-term services and supports needs. The Contractor's Medical Director shall be responsible for ensuring the clinical accuracy of the Contractor's authorization determinations involving Medical Necessity. If the Contractor expects to issue an Adverse Action based on Medical Necessity, the Contractor's authorization determination must first be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of the Medicare and Medicaid coverage criteria. The physician or other healthcare professional who reviews the Contractor's Adverse Actions based on Medical Necessity must have a current and unrestricted license to practice within his or her profession;

c. The Enrollee, or a Provider on behalf of an Enrollee, may request authorization orally or in writing, except for requests for payment, which must be in writing (unless the Contractor has implemented a voluntary policy of accepting verbal payment requests). The Contractor must notify the Provider of decisions on Service Authorization Requests and related notices as specified in **Section 2.8.B**. The notices shall be issued as expeditiously as the Enrollee's health condition requires but no later than 14 days after the receipt of the request for service. The Contractor may extend the 14 day deadline by up to 14 additional calendar days if the Enrollee requests the extension or if the Contractor justifies a need for additional information and how the delay is in the interest of the Enrollee. When the Contractor extends the deadline, it must notify the Enrollee in writing of the reasons for the delay and inform the Enrollee of the right to file a Grievance if he or she disagrees with the Contractor's decision to grant an extension. The Contractor must notify the Enrollee of its determination as expeditiously as the Enrollee's health condition requires, but no later than upon expiration of the extension;

d. An Enrollee, or a provider on behalf of an Enrollee, may request an expedited authorization determination orally or in writing. In the event a Provider indicates, or the Contractor determines, that the timeframe described at **Section 2.4.14.c** could seriously jeopardize an Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function, the Contractor must make a service authorization decision and provide notice to the Enrollee as expeditiously as the Enrollee's health condition requires but no later than 72 hours after the receipt of the request for service;

e. In addition to the requirements imposed by law and regulation – including but not limited to 130 CMR 450.117(J)(2) – the Contractor and any of its subcontractors with prior authorization authority, must provide medical necessity criteria for authorization of services upon the request of an Enrollee, a Network Provider, or the MassHealth agency. This requirement may be fulfilled by publishing the criteria on the Contractor's website; and

f. 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.

g. The Contractor shall specify that prior authorization shall not be required for the

following services as defined in **Appendix A**, **Exhibit 1**:

1) Inpatient Substance Use Disorder Services (Level 4).

2) Inpatient Mental Health Services. The Contractor must require hospitals to notify the Contractor of the admission of a Covered Individual for inpatient mental health services and the Covered Individual's initial treatment plan within 72 hours of admission.

16. Utilization Management Activities

If the Contractor provides compensation to individuals or entities to conduct utilization management activities, compensation for these activities 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.

B. Primary, Acute, and Preventive Care

1. PCP Clinical Responsibilities

The PCP must:

a. Provide overall clinical direction and serve as a central point for the integration and coordination of the Covered Services listed in **Appendix A**. For individuals with Complex Care Needs, a PCT must be created and the PCP must participate as needed (see **Section 2.4.B.2**; and

b. Assume clinical responsibility for each Enrollee upon the effective date of enrollment including, but not limited to:

1) Making an initial clinical determination of Emergency Conditions, Urgent Care, or routine Enrollee status;

2) Providing for the transition of existing services, equipment, and other resources to ensure safe, efficient continuity of care at enrollment;

3) Providing primary medical services, including acute and preventive care; and

4) Referring the Enrollee to specialty, long term care, and behavioral health Providers, as medically appropriate.

2. Care Management Responsibilities of the PCP or his or her designee on the PCT.

As the manager of care, the PCP or the PCP's designee must:

a. With the Enrollee and the Enrollee's designated representative, if any, develop an IPC;

b. In the presence of Complex Care Needs, implement a comprehensive evaluation process to be performed by a PCT, which will include an in-home or in-facility component. Enrollees with Complex Care Needs will have their care managed by a PCT;

c. On an ongoing basis, consult with and advise acute, specialty, long term care, and

behavioral health Providers about care plans and clinically appropriate interventions;

d. Conduct Ongoing Assessments appropriately and, as required in this Contract, adjust Individualized Plans of Care as necessary and with Enrollee's knowledge and consent, and communicate the information to the Enrollee's Providers in timely manner;

e. With the assistance of the GSSC, if any, promote independent functioning of the Enrollee and provide services in the most appropriate, least restrictive environment;

f. Document and comply with advance directives about the Enrollee's wishes for future treatment and health care decisions;

g. Assist in the designation of a health care proxy, if the Enrollee wants one;

h. Maintain the CER, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Enrollee (see **Section 2.4.A.8-10)**; and

i. Communicate with the Enrollee, and the Enrollee's family members and significant caregivers, if any and as appropriate under HIPAA, about the Enrollee's medical, social, and psychological needs.

C. Long Term Care

1. Long Term Care Delivery System

   In delivering the Covered Services referenced in **Appendix A** that relate to long term care services, the Contractor must demonstrate the capacity to provide coordination of care and expert care management through the PCT. The Contractor must ensure that:

   a. The PCT arranges, delivers, and monitors long term care services on an ongoing basis; and

   b. The measurement of the Functional Status of Enrollees is performed at Initial and Ongoing Assessments. Reports will be produced in accordance with **Section 2.13.E**.

2. Continuum of Long-Term Care

   The Contractor must arrange and pay for:

   a. Community alternatives to institutional care (see **Appendix A**);

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

   c. Nursing facility services for Enrollees who meet applicable screening requirements (in accordance with 130 CMR Chapter 456 and Chapters 515 through 524) and for whom the Contractor has no community service package appropriate and available to meet the Enrollee's medical needs; and

   d. Other institutional services as determined by the PCT.

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

The Contractor must comply with federal regulations requiring referral of nursing facility eligible Enrollees, as appropriate, for PASRR evaluation for mental illness and developmental disability treatment pursuant to the Omnibus Budget Reconciliation Act of 1987, as amended, and 42 CFR 483.100 through 483.138. Among other things, the Contractor shall not pay for nursing facility services rendered to an Enrollee during a period in which the nursing facility has failed to comply with PASRR with respect to that Enrollee. In any instance in which the Contractor denies payment in accordance with this section, in addition to any prohibitions on balance-billing set forth in this Contract (including **Section 5.1.K.5**), the Contractor shall ensure that the Provider does not attempt to bill the Enrollee for such services.

D. Behavioral Health

1. Systematic Early Identification and Intervention for Behavioral Health Services

   Behavioral health conditions must be systematically identified and addressed by the Enrollee's PCP or PCT at the Initial and Ongoing Assessments through the use of appropriate mental-health screening tools as designated or approved by EOHHS. When appropriate, the Contractor must ensure that referrals for specialty behavioral health services are made promptly, monitored, and documented in the CER.

2. Services for Enrollees with Serious and Persistent Mental Illness

   The Contractor must ensure that Enrollees with serious and persistent mental illness have access to ongoing medication review and monitoring, day treatment, and other milieu alternatives to conventional therapy. The PCT must coordinate services with additional support services the member may be receiving, including but not limited to services provided by or through state agencies such as DMH or DDS, as appropriate. For such Enrollees, a qualified behavioral health clinician (see **Section 2.5.B**) must be part of the PCT. As necessary, care coordination with the Department of Mental Health must be provided.

3. Continuum of Behavioral Health Care

   The Contractor must offer a continuum of behavioral health care that is coordinated with PCPs or PCTs, as appropriate, and includes but is not limited to:

   a. A range of services from acute inpatient treatment to intermittent professional and supportive care for delivering behavioral health services to Enrollees residing in the community or in nursing facilities; and

   b. Diversionary services that offer safe community alternatives to inpatient hospital services. (See **Appendix A**.)

4. Behavioral Health Responsibilities

   The Contractor must manage the provision of all behavioral health services. When services for Emergency Conditions are needed, the Enrollee may seek care from any qualified behavioral health Provider. The care-management protocol for Enrollees must

encourage appropriate access to behavioral health care in all settings. For Enrollees who require behavioral health services, the behavioral health Provider must:

a. With the Enrollee and the Enrollee's designated representative, if any, develop the behavioral health portion of the IPC for each Enrollee in accordance with accepted clinical practice. The IPC must be signed or otherwise approved by the Enrollee or the Enrollee's designated representative, if any;

b. With the input of the PCP or PCT, as appropriate, determine clinically appropriate interventions on an on-going basis, with the goal of promoting the independent functioning of the Enrollee;

c. Make appropriate and timely entries into the CER about the behavioral health assessment, diagnosis determined, medications prescribed, if any, and Individualized Plan of Care developed. As stated in **Section 2.4.A.10.d**, psychotherapeutic session notes must not be recorded in the CER; and

d. Obtain authorization from the PCP or PCT, as appropriate, for any non-emergency services, except when authorization is specifically not required under this Contract.

5. Coordination of Medication

   Prescriptions for any psychotropic medications must be evaluated for interactions with the medications already prescribed for the Enrollee. (See **Section 2.13.A.2**.)

6. Behavioral Health Needs Management

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

7. The Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for behavioral health services set forth in **Appendix A** as most recently adopted by the American Medical Association and CMS; and shall pay no less than the MassHealth rate for such CPT codes.

8. Substance Use Disorder Services

   a. Prior authorization shall not be required for the following services:

      1) Inpatient Substance Use Disorder Services (Level IV), as defined in **Appendix A**, **Exhibit 1**;

      2) Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7), as defined in **Appendix A**, **Exhibit 1**;

      3) Clinical Support Services (CSS), as defined in **Appendix A**, **Exhibit 1**, for Substance Use Disorders (Level III.5). The Contractor may implement utilization review procedures on the seventh day of a patient's stay for CSS, but shall not make any utilization review decisions that impose any restriction or deny any future medically necessary CSS unless a patient has received at least 14 consecutive days of CSS;

4) The following Outpatient Services: Counseling (including Couples/Family Treatment, Group Treatment, and Individual Treatment) and Ambulatory Detoxification, as defined in **Appendix A**, **Exhibit 1**;

5) The following Non-24-Hour Diversionary Services: Structured Outpatient Addiction Program (SOAP), as defined in **Appendix A**, **Exhibit 1**;

6) Intensive Outpatient Program (IOP), as defined in **Appendix A**, **Exhibit 1**;

7) Partial Hospitalization as defined in **Appendix A**, **Exhibit 1**, with short-term day or evening mental health programming available seven days per week; and

8) The initiation or re-initiation of a buprenorphine/naloxone prescription of 32 mg/day or less, for either brand formulations (e.g. Suboxone™, Zubsolv™, Bunavail™) or generic formulations, provided, however, that the Contractor may have a preferred formulation. Contractor may establish review protocols for continuing prescriptions. Notwithstanding the foregoing, the Contractor may implement prior authorization for buprenorphine (Subutex™) and limit coverage to pregnant or lactating women and individuals allergic to naloxone, provided such limitations are clinically appropriate.

b. Providers providing Clinical Support Services for Substance Use Disorders (Level III.5) and Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7) shall provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the Enrollee, information regarding the Enrollee's coverage with the Contractor, and the provider's initial treatment plan. Contractor may not use failure to provide such notice as the basis for denying claims for services provided. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee.

c. 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:

1) Safety edits, including but not limited to, as further directed by EOHHS:

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

b) Implementing a safety edit for concurrent chronic use of opioids and benzodiazepines, and review automated processes;

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

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

3) 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

4) Any required claims review automated processes."

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

9. Community Support Program (CSP) Services for Chronically Homeless Individuals

   Subject to the Medical Necessity requirements set forth in 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP services as set forth in **Appendix A**, **Exhibit 1**, **Section B.1** to eligible Enrollees as defined in this section.

   a. For purposes of this **Section 2.4.D.9**, an eligible Enrollee shall be an Enrollee that either (a) received CSP services at the time of enrollment or (b) is Chronically Homeless.

   b. The Contractor shall authorize, arrange, coordinate, and provide CSP services, as set forth in **Appendix A, Exhibit 1, Schedule B.1**, to eligible Enrollees, which shall include, at a minimum:

      1) Assisting in enhancing daily living skills;

      2) Providing service coordination and linkages;

      3) Assisting with obtaining benefits, housing and healthcare;

      4) Developing a crisis plan;

      5) Providing prevention and intervention; and

      6) Fostering empowerment and recovery, including linkages to peer support and self-help groups.

10. Community Support Program (CSP) Services for Individuals with Justice Involvement (CSP-JI)

    a. 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 A, Exhibit 1**, to individuals with Justice Involvement as described in this section. The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in **Appendix A, Exhibit 1**, to Enrollees with Justice Involvement that consist of

intensive, and individualized support delivered face-to-face or via telehealth, as further specified by EOHHS, which shall include:

1) Assisting in enhancing daily living skills:
2) Providing service coordination and linkages;
3) Assisting with obtaining benefits, housing, and healthcare;
4) Developing a safety plan;
5) Providing prevention and intervention; and
6) Fostering empowerment and recovery, including linkages to peer support and self-help groups.

b. For the purpose of this **Section 2.4.D.10**, Enrollees with Justice Involvement shall be those individuals released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.

c. The Contractor shall, as further directed by EOHHS, with respect to CSP-JI:

1) Actively communicate with CSP-JI providers regarding the provision of CSP-JI services, including coordinating care to ensure that individuals' needs are met;
2) Ensure that network providers of CSP-JI have demonstrated experience and engage in specialized training;
3) Report to EOHHS about its network providers of CSP-JI in accordance with **Appendix D**; and
4) Designate a single point of contact for CSP-JI to provide information to CSP-JI providers and EOHHS as further specified by EOHHS.

d. When directed by EOHHS, the Contractor shall maintain agreements with Behavioral Health Supports for individuals with Justice Involvement providers, as further specified by EOHHS.

11. Community Behavioral Health Center (CBHC) Program

The Contractor shall, as further directed by EOHHS:

a. Effective January 3, 2023, execute and maintain contracts with CBHCs identified in Appendix A, Exhibit 4, and pay CBHCs no less than the payment rates established by EOHHS in 101 CMR 305.000 and shall use procedure codes as directed by EOHHS to provide payment for the following services rendered by CBHCs: Adult Community Crisis Stabilization and Adult Mobile Crisis Intervention.

b. Effective July 1, 2023, pay CBHCs no less than the payment rates established by EOHHS in 101 CMR 305.000 and shall use procedure codes as directed by EOHHS to provide payment for the outpatient behavioral health services paid for through the encounter bundled rate, as set forth in 101 CMR 305.000.

c. Not require prior authorization for any services provided by CBHCs.

E. Health Promotion and Wellness Activities

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

1. Exercise;
2. Preventing falls;
3. Adjustment to illness-related changes in functional ability;
4. Adjustment to changes in life roles;
5. Smoking cessation;
6. Nutrition;
7. Prevention and treatment of alcohol and substance abuse; and
8. Coping with Alzheimer's disease or other forms of dementia.

F. Continuity of PCA Services for Enrollees During Disenrollment

Upon the disenrollment of an Enrollee who receives PCA services, in addition to any other continuity of care requirements imposed by law, regulation, or this Contract, the Contractor must comply with EOHHS-prescribed continuity of PCA service procedures.

G. Continuity of Care Period for Passively Enrolled individuals

1. For all Covered Services, the Contractor must develop policies and procedures to ensure continuity of care for all Passively Enrolled Enrollees for at least 90 calendar days after the effective date of each such Enrollee's enrollment with the Contractor. Unless an Enrollee agrees to the implementation of the IPC prior to the expiration of this 90-day period, during this 90-day period, the Contractor must, at a minimum:
   a. Allow Enrollees to remain with their current providers and make payment to such providers at current MassHealth fee-for-service provider rates, even if such providers are not part of the Contractor's Provider Network;
   b. Honor all prescriptions for covered drugs that were issued prior to the completion of the IPC;
   c. Honor all prior authorizations that MassHealth issued prior to the completion of the IPC; and
   d. Prevent gaps in the provision of Covered Services by ensuring that Enrollees are promptly linked with Network Providers following the completion of the IPC.
   e. The Contractor must also notify the provider of the services that the services will no longer be authorized.

2. If, as a result of the development of the IPC or the Initial Assessment, the Contractor proposes modifications to the Enrollee's prior authorized services, the Contractor must notify the Enrollee, in writing, of his or her opportunity to appeal the proposed modifications. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in **Section 2.8** of this Contract.
3. If, prior to Enrollment, an Enrollee is receiving a service that the Contractor will not cover after the end of the 90-day continuity of care period described in **Section 2.4.G.1**, the Contractor must inform the Enrollee of this fact, in writing, prior to the end of the 90-day continuity of care period, using the procedure set forth at 42 CFR 438.404 and 42 CFR 422.568. Upon receipt of such notice, the Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in **Section 2.8** of this Contract.

Section 2.5 Provider Network

A. General

1. Through the execution of Provider Agreements, the Contractor must maintain and monitor a Provider Network that is sufficient to provide all Enrollees, including those with limited English proficiency or physical or mental disabilities, with access to the full range of Covered Services, including behavioral health services, other specialty services, and all other services required under this Contract (see Covered Services in **Appendix A**). Pursuant to 42 CFR 438.608(b), the Contractor shall ensure that all such providers are enrolled with MassHealth as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR 455, subparts B and E. The Contractor must notify EOHHS of any Provider Network changes that impact Enrollee access to Covered Services within five business days.
2. The Contractor may execute network provider agreements pending the outcome of EOHHS's screening, enrollment, and revalidation process described in **Section 2.5.A.1** of up to 120 days, but must terminate a network provider 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, and notify affected Enrollees.
3. The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for 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;
4. 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;
5. If the Contractor declines to include individuals or groups of Providers in its Provider Network, the Contractor must give the affected Providers written notice of the reason for its decision. Pursuant to 42 CFR 438.12(b) this requirement may not be construed to require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees, or preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or to preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs consistent with its responsibilities to Enrollees.
6. The Contractor must comply with all applicable requirements and standards set forth at 42 CFR 422.112; 422 Subpart E; 422.504(a)(6) and 422.504(i); 422 Subpart K, 423 Subpart C; and other applicable federal laws and regulations related to managed care entity relationships with providers and with related entities, contractors and subcontractors for services in the Contractor's Medicare Advantage Special Needs Plan for persons dual eligible for Medicare and Medicaid and with Medicare Part D authority.
7. The Contractor may use different reimbursement amounts for different specialties and for different practitioners in the same specialty.
8. The Contractor may not employ or contract with Providers excluded from participation in

federal health care programs under either section 1128 or section 1128A of the Social Security Act.

9. The Contractor shall ensure that Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this Contract;
10. To support the Contractor's development of its Provider Network, EOHHS will provide the Contractor with information on Medicaid provider participation, such as through EOHHS' online provider directory.
11. The Contractor shall assure EOHHS that it has the capacity to service expected enrollment of Enrollees in accordance with the access standards specified in **Section 2.5.A** and **Section 2.6** by submitting the access and availability reports specified in **Appendix D**.
    a. The Contractor must submit these reports on a quarterly basis and whenever there is a significant change in operations that would affect the adequacy and capacity of services. Such significant changes include, but are not limited to:
        1) Changes in Covered Services;
        2) Enrollment of a new population in the Contractor's plan;
        3) Changes in benefits;
        4) Changes in Network Provider payment methodology
        5) Changes in geographic service area; and
        6) Changes in composition of the provider network.
    b. In these reports, the Contractor must demonstrate that it maintains a Provider Network that:
        1) Is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in each of the State's regions;
        2) Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports that is adequate for the anticipated number of Enrollees in the Contractor's service area; and
        3) Includes sufficient family planning providers to ensure timely access to covered services.
    c. If the Contractor does not comply with the access standards specified in **Section 2.5.A** and **Section 2.6**, the Contractor shall take corrective action necessary to comply with such access standards.
12. The Contractor may not restrict an Enrollee's free choice of family planning services and supplies providers.

B. 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 D** 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 department(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 2.9**, utilization management information collected pursuant to **Section 2.14.B**, and Enrollee satisfaction surveys collected pursuant to **Section 2.12.C**;

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 J**, at the frequency described in **Appendix J** as follows.

   a) The Contractor shall search the databases in **Appendix J** 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 J**;

   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 D**, which demonstrates the Contractor's compliance with this section. 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 J**; 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.

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;

4) On an annual basis, the Contractor shall submit to EOHHS a certification checklist set forth in **Appendix D** 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 cause prior to the ultimate 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;

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;

j. Search and do not contract with the names of parties disclosed during the credentialing process in the databases in **Appendix J**, in accordance with the Contractor's obligations set forth in **Section 2.5.B.1.f.i**, 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, 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, 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 J**. 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 to facilitate EOHHS efforts to standardize Provider enrollment or credentialing processes between EOHHS and the Contractor.

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(s). 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 2.5.B.1-2** 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 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 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).

5. Frail Elder Waiver Provider Credentialing

In addition to the provider credentialing and qualification requirements set forth in this Contract, the Contractor shall ensure that, for all providers who provide services to FEW Enrollees, such providers meet the provider qualification, certifications, and other requirements set forth in Appendices C-1 and C-3 of the Frail Elder Waiver (**Appendix P**).

C. Provider Qualifications and Performance

1. Written Provider Protocols

In addition to the credentialing and re-credentialing processes described above, the Contractor must have and comply with written protocols in the following areas:

a. Practice guidelines, in accordance with 42 CFR 438.236. The Contractor must disseminate such practice guidelines to Enrollees and Potential Enrollees upon request;

b. Provider profiling activities, defined as multi-dimensional assessments of a Provider's performance. The Contractor must use such measures in the evaluation and management of each component of the Provider Network. At a minimum, the Contractor must address the following:

1) Mechanisms for detecting both underutilization and overutilization of services;

2) Resource utilization of services, including specialty and ancillary services;

3) Clinical performance measures on structure, process, and outcomes of care;

4) Interdisciplinary team performance, including resolution of service plan disagreements;

5) Enrollee experience and perceptions of service delivery; and

6) Timely access.

c. A corrective action process for Providers whose performance is unacceptable in one or more of the areas noted in **Section 2.5.C.1.d** above. For serious complaints involving medical Provider errors, the Contractor must take immediate corrective action and file reports of corrections made with the CMS and EOHHS within three business days of the complaint.

2. Primary Care Qualifications

The Enrollee's care will be managed by a PCP or his or her designee on a PCT. The PCP and the members of the PCT must meet the following qualifications.

a. Physician

A physician serving as the PCP must:

1) Be licensed by the Massachusetts Board of Registration in Medicine:

2) Obtain annual continuing medical education units in geriatric practice;

3) Have at least two years' experience in the care of persons over the age of 65; and

4) Be a Provider in good standing with the federal Medicare program.

b. Registered Nurse or Nurse Practitioner

A nurse practitioner serving as the PCP or registered nurse or nurse practitioner serving as a member of a PCT must:

1) Be licensed by the Massachusetts Board of Registration of Nursing,

2) Obtain annual continuing education units in geriatric practice; and

3) Be certified as a geriatric nurse practitioner or demonstrate at least two years' professional experience in the care of persons over the age of 65.

c. Physician Assistant:

A physician assistant serving as the PCP or as a member of a PCT must:

1) Be licensed by the Board of Registration of Physician Assistants;

2) Obtain annual continuing education units in geriatric practice; and

3) Demonstrate at least two years' professional experience in the care of persons over the age of 65.

3. Subcontracting Requirements

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

b. All 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 Subcontractor checklist using the template provided by EOHHS and attached hereto as **Appendix K**, and completed federally required disclosure forms (see **Appendix G**), if required in accordance with **Section 2.5.B.1.k**, at least 60 days prior to the date the Contractor expects to execute the Subcontract. Among other things required in the checklist, the Contractor must describe the process for selecting the Subcontractor, including the selection criteria used. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the checklist.

c. A GSSC must meet the standards established by the EOEA in designating ASAPs as qualified to serve as GSSCs.

d. The 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 Subcontractor is obligated to provide;

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

   4) Require the Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance, and provisions of this Contract;

   5) Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the Subcontract requires the Subcontractor to agree that:

      a) The State (including EOHHS), CMS, the HHS Inspector General, the Comptroller General, or their designees, have the right to audit, evaluate, and inspect its books, records, contracts, computers, or other electronic systems that pertain to any services or activities performed, or the determination of any 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) It will make available, for the purposes of an audit, evaluation or inspection described in this subsection, its premises, physical facilities, equipment, books, records, contracts, computers or other electronic systems relating to its Medicaid Enrollees;

e. The Contractor shall monitor any 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 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 Subcontractor, or being notified by such 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.

g. In accordance with **Appendix D**, the Contractor shall submit to EOHHS an annual list of all Subcontractors. Such annual report shall include notification if any of its 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 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 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, 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.

D. Provider Training

The Contractor must:

1. Inform its Provider Network about the program, including all Covered Services contained in **Appendix A**;
2. Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services through the provision of a Provider-training curriculum, flow charts, and other written materials to enhance coordination and linkage;
3. Inform its Provider Network about the procedures and timeframes for Enrollee Grievances and Appeals (both internal and external);
4. Develop and provide continuing education programs for members of the Provider Network, including but not limited to:
   a. Identification and management of depression, alcohol and substance abuse, and dementia including Alzheimer's disease;
   b. Identification and treatment of incontinence;
   c. Preventing falls;
   d. Identification of and mandatory reporting requirements for abuse, neglect, and exploitation of elderly individuals;
   e. Coordination of care within the Provider Network, including instructions regarding policies and procedures for maintaining the CER;
   f. The requirements of this contract related to continuity of care; and
   g. The NCQA approved model of care required under Social Security Act Section

1859(f)(7) including care management roles and responsibilities of each member of the ICT.

5. Instruct and assist the Providers in the Contractor's Provider Network in the process and need for verifying each Enrollee's MassHealth eligibility and enrollment in MassHealth prior to providing any services, and at each point of service, through EOHHS's electronic on-line Eligibility Verification System (EVS). The Contractor and its Providers shall not require such verification prior to providing Emergency Services and without resulting in discrimination against the Enrollee.
6. Upon EOHHS's issuance of continuity of PCA service procedures for Enrollees receiving PCA services that are disenrolling from the Contractor, the Contractor must include provisions in its contracts with PCM Agencies requiring that those PCM Agencies follow those procedures.
7. The Contractor must include provisions in its contracts with its PCM Agencies requiring that the PCM Agencies instruct Enrollees regarding appropriate utilization of PCA overtime requiring authorization pursuant to 130 CMR 422.418(C), in accordance with 130 CMR 422.421(B)(1)(b)(5). For the avoidance of doubt, any Contractor contracting with a PCM Agency to provide PCM Services shall require such PCM Agency to agree to:
    a. Attend trainings as directed by EOHHS;
    b. Comply with reporting requirements for PCA services as directed by EOHHS;
    c. Respond to Enrollee inquiries regarding overtime management and overtime approval requests;
    d. Educate Enrollees that do or may need to schedule PCAs for more than 50 hours per week regarding the scheduling requirements pursuant to 130 CMR 422.420(A)(5)(b) and 130 CMR 422.418(C) and the potential consequences pursuant to 130 CMR 422.420(B)(5);
    e. Assist Enrollees that do or may need to schedule PCAs to work more than 50 hours per week by working with those Enrollees to identify additional resources to enable such Enrollees to hire additional PCAs to meet the scheduling requirements;
    f. Provide an overtime approval request form for Enrollees who request it, provide related instruction in completing the form to request overtime approval, and work with Enrollees to obtain Enrollee and PCA signatures;
    g. Review and submit completed overtime approval request forms within one business day of receipt of said forms to MassHealth in a manner prescribed by MassHealth and maintain the original and related documents, if any, in the Enrollee's file;
    h. Communicate MassHealth's decisions regarding overtime approval requests within one business day to Enrollees and to the Contractor;
    i. Assist Enrollees who are denied overtime approval requests, or Enrollees who are approved for a short-term continuity of care overtime approval requests, by:
        1) Working with the Enrollee to identify additional resources to enable Enrollee to hire additional PCAs;

2) Working and communicating with the FI regarding overtime approval requests and decisions;

3) Working and communicating with the Contractor regarding the statuses of Enrollees who have been approved to schedule overtime, Enrollees who have not been approved to schedule overtime but who have applied for an overtime approval, and Enrollees who are not in compliance with the MassHealth overtime scheduling requirements pursuant to 130 CMR 422; and

4) Informing Enrollees about their appeal rights with the MassHealth Board of Hearings pursuant to 130 CMR 610.

j. Receive and maintain lists from FIs that identify Enrollees who employ PCAs that work more than 50 hours per week; and

k. Prioritize the list of existing Enrollees who employ PCAs that work more than 50 hours per week and contact such Enrollees in order of priority to identify and assess each Enrollee's need for scheduling one or more PCAs for overtime.

Such requirements shall apply to this **Section 2.5.D.7** regardless of whether the PCM Agency also participates in the MassHealth Personal Care Management program.

E. Provider Network Directory

The Contractor shall:

1. Develop and make available a Network Provider directory that identifies the Contractor's Network Providers. The directory shall include each Network Provider's:
   a. Name, as well as any group affiliation;
   b. Street address(es);
   c. Telephone number(s);
   d. Web site URL (if applicable);
   e. Specialty(ies) (if applicable);
   f. Ability to accept new Enrollees;
   g. Cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;
   h. Office's/facility's accommodations for people with physical disabilities, including offices, exam room(s), and equipment;
   i. Office hours;
   j. For behavioral health providers, licensing information;
   k. Accessibility by public transportation;
   l. Special experience, skills, training, and/or expertise in treating:

1) Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2) Homeless persons;

3) Persons with co-occurring mental health and substance abuse conditions (also known as “Dual Diagnosis”); and

4) Other specialties.

2. Maintain the Network Provider directory required by this section in both electronic and paper form as follows:

   a. Paper Version – The Contractor shall update its paper provider directory at least monthly.

   b. Electronic Version – The Contractor shall maintain an up-to-date version of the Network Provider Directory on the Contractor’s website that is available to the general public. The Contractor shall update this electronic directory no later than 30 calendar days after the Contractor receives updated provider information. The Contractor shall maintain this electronic directory in a machine-readable file and format. At a minimum, the Contractor shall maintain this electronic directory in such a fashion that enables users of the Contractor’s website to search by:

      1) Provider name;

      2) Town;

      3) ZIP code;

      4) Provider specialty;

      5) Provider languages spoken; and

      6) Provider licensing information.

   3. Within a reasonable time after EOHHS enrolls a new Enrollee, provide each such individual with notification that a copy of the Network Provider Directory can be accessed online at the Contractor’s website, and is available in writing upon request by calling the Member and Provider Services Department;

   4. At EOHHS’s discretion, provide written notice to Enrollees of any changes in the Network Provider Directory at least 30 days before the intended effective date of the change or as soon as the Contractor becomes aware of such change;

   5. In the event of the termination of a Network Provider, provide written notice within 15 days after receipt or issuance of the termination notice to each Enrollee who received his or her primary care from, was seen on a regular basis by, or was seen within the previous 90 days by, the terminated Provider, and ensure that care is transferred to another Network Provider in a timely manner to minimize any disruptions to treatment; and

   6. Provide annual notification to Providers, Enrollees and other interested parties that the most current version of the Network Provider Directory is available on the

Contractor's website and that hard copies are available on request.

F. Non-Payment for Provider-Preventable Conditions

Pursuant to 42 CFR 438.3(g), the Contractor must:

1. Provide that no payment will be made by the Contractor to a Provider for a Provider Preventable Condition as defined in this Contract.
2. Require, as a condition of payment from the Contractor that all Providers in its Provider network comply with reporting requirements on Provider-Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by EOHHS.
3. Not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.
4. A Contractor reduction in provider payment may be limited to the extent that the following apply:
    a. The identified Provider-Preventable Condition would otherwise result in an increase in payment.
    b. The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition.
    5. Ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services.

G. 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" (SREs) (a/k/a "Never Events"), as defined by this Contract, occur. The Contractor's standards for non-payment or recovery of payment shall be, to the extent feasible, consistent with the minimum standards for non-payment for such events developed by EOHHS and provided to Contractors via regulation and administrative bulletins.
2. The Contractor shall notify EOHHS and CMS of SREs, in accordance with guidelines issued by the Department of Public Health.
3. The Contractor shall provide EOHHS an annual summary of SREs. Such summary shall include the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE.

H. Hospital ED-based Crisis Evaluation

1. Effective January 3, 2023, the Contractor shall pay hospitals for Emergency Department-based behavioral health crisis evaluations as set forth in **Appendix A, Exhibit 1** at no less than the rate specified by EOHHS. Hospitals may sub-contract these services out to behavioral health providers, including crisis teams, but hospitals shall be solely responsible for billing the Contractor. In addition, the Contractor shall direct hospitals to deliver ED-based behavioral health crisis evaluations in accordance with the Acute Hospital RFA as specified by EOHHS.

2. Once all hospitals have established procedures for Emergency Department-based behavioral health crisis evaluations, as determined by EOHHS, the Contractor shall not make payments to Emergency Service Programs and evaluations provided in the Emergency Department.

Section 2.6 Enrollee Access to Services

A. General

The Contractor:

1. Must demonstrate its ability to meet the needs of Enrollees competently and promptly;
2. Must offer adequate choice and availability of Providers, and allow each Enrollee to choose his or her Provider to the extent possible and appropriate;
3. Must provide adequate access to Covered Services (listed in **Appendix A**), including physical and geographic access. Such access must be designed to accommodate the needs of Enrollees who are disabled or non-English speaking, including access to TTY (for the deaf and hard of hearing) and translation services;
4. Must provide all Covered Services in an amount, duration, type, frequency and scope that is no less than the amount, duration, type, frequency and scope for the same services provided under MassHealth fee for service.
5. Must provide all Covered Services that are medically necessary pursuant to 130 CMR 450.204, including those Covered Services that:
   a. Prevent, diagnose, and treat health impairments;
   b. Achieve age-appropriate growth and development;
   c. Attain, maintain, or regain functional capacity; and
   d. Provide an opportunity for an Enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or choice.
6. Must ensure that all Covered Services are sufficient in an amount, duration, type, frequency or scope to reasonably achieve the purpose for which the services are furnished;
7. Except for the services described in the FEW, the Contractor may place appropriate limits on a Covered Service for the purpose of utilization control, provided that:
   a. The furnished services can reasonably be expected to achieve their purpose;
   b. Services supporting Enrollees with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports;
   c. Family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used; and
   d. 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™) as a Medicaid Covered Service. The Contractor must cover Vivitrol™ as a pharmacy and medical benefit. If the Contractor covers Vivitrol™ as a Medicaid Covered Service through a specialty pharmacy benefit, the Contractor shall allow Enrollees accessing that benefit 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.

8. May place appropriate limits on a Covered Service on the basis of Medical Necessity. 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 the definition of Medical Necessity in this Contract and therefore no more restrictive than MassHealth Medical Necessity guidelines, including quantitative treatment limits and nonquantitative treatment limits;
   c. Developed in accordance with the definition of Medical Necessity in this Contract and therefore no more restrictive than MassHealth Medical Necessity guidelines;
   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.
9. Must submit changes to its Medical Necessity guidelines, program specifications and services components for all Covered Services to EOHHS no less than 60 days prior to any change, or another timeframe specified by EOHHS;
10. Must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee;
11. Must comply with all federal requirements regarding the provision of services, including but not limited to 42 CFR 431.51(b)(2) and 42 CFR 441.202;
12. Must make interpretation services, including oral interpretation, and auxiliary aids and services, such as TTY/TDY and American Sign Language (ASL), available upon request of each Enrollee or Potential Enrollee at no cost; and
13. Must ensure that access to Covered Services for Enrollees is consistent with the degree of urgency, as follows:
   a. Emergency Services shall be provided immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any qualified Provider, whether a Network Provider or a non-Network Provider.
   b. ESP Services shall be provided immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present, including Enrollees, uninsured individuals and persons covered by Medicare only.
   c. Urgent Care Services shall be provided within 48 hours.
   d. Unless otherwise specified in this contract, all other care shall be provided in accordance with usual and customary community standards, and in all cases within 14 calendar days.
   e. In accordance with 42 CFR 438.206(c)(1)(iii), the Contractor shall make Covered Services available 24 hours a day, seven days a week when medically necessary.

14. Must ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to individuals with commercial insurance, or comparable to Medicaid Fee-for-Service if the Network Provider serves only MassHealth Members;
15. Must ensure that, in the event the Contractor's Provider Network is unable to provide necessary services covered under this Contract to a particular Enrollee, the Contractor will adequately and timely cover the services out of network, for as long as the Contractor's Provider Network is unable to provide such services; and
16. Must provide services to meet the requirements of a Fully Integrated Dual Eligible Special Needs Plan, as set forth in 42 CFR 422.2, including coverage of nursing facility services for a period of at least 180 days during the plan year.

B. Time, Distance, and Other Adequacy Standards

1. For each of the following Provider types, the Contractor shall adhere to CMS's most current Medicare Advantage network adequacy criteria, including time and distance standards, that apply to the Contractor's service area:
    a. Primary Care;
    b. Obstetrics and Gynecology (OB/GYN);
    c. Specialist Providers;
    d. Hospital; and
    e. Pharmacy.
2. The Contractor shall adhere to the time and distance standards that follow for each of the following provider types:
    a. Outpatient Behavioral Health: Each Enrollee must have a choice of at least two Outpatient Behavioral Health Providers within a 15-mile radius or 30 minutes from the Enrollee's zip code of residence.
    b. Mental Health Providers: Each Enrollee must have a choice of at least two Mental Health Providers within twenty (20) miles or forty (40) minutes travel time from the Enrollee's ZIP code of residence.
    c. Substance Use Disorder Providers: Each Enrollee must have a choice of at least two Substance Use Disorder Providers within twenty (20) miles or forty (40) minutes travel time from the Enrollee's ZIP code of residence.
3. For each of the Covered Services that follow, unless otherwise specified by EOHHS, each Enrollee must have a choice of at least two Providers that are either within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence, except that with prior approval from EOHHS, the Contractor may offer the Enrollee only one such Provider per service:
    a. Adult Day Health;
    b. Day Habilitation;
    c. Hospice; and
    d. The following services described in the Frail Elder Waiver:

1) Evidence Based Education Programs;

2) Respite; and

3) Supportive Day Program.

4. For each of the Covered Services that follow, each Enrollee must have a choice of at least two Providers that will deliver services at the Enrollee's residence:
   a. Adult Foster Care;
   b. Private Duty Nursing; and
   c. The following services described in the Frail Elder Waiver:
      1) Alzheimer's/Dementia Coaching;
      2) Chore;
      3) Companion;
      4) Complex Care Training and Oversight (formerly Skilled Nursing);
      5) Enhanced Technology/Cellular Personal Emergency Response System (PERS);
      6) Environmental Accessibility Adaptation;
      7) Goal Engagement Program;
      8) Grocery Shopping and Delivery;
      9) Home Based Wandering Response Systems;
      10) Home-Delivered Meals;
      11) Home Delivery of Pre-Packaged Medications;
      12) Home Health Aide;
      13) Home Safety/Independence Evaluations (formerly Occupational Therapy);
      14) Homemaker;
      15) Laundry;
      16) Medication Dispensing System;
      17) Orientation and Mobility Services;
      18) Peer Support;
      19) Personal Care;
      20) Supportive Home Care Aide;
      21) Transitional Assistance; and
      22) Transportation.

5. For Enrollees receiving Personal Care Attendant Services, the Contractor shall ensure that each such Enrollee has the right to hire, fire, schedule, and train his or her Personal Care Attendant, in accordance with 130 CMR 422.420(A)(6).

6. The Contractor shall monitor gaps in service for each Provider type that travels to Enrollees to deliver services and log all complaints related to such gaps in service. This includes missed or late visits. The contractor shall submit to EOHHS on a quarterly basis a complaint log that provides detail on provider name, type, and complaint detail (date, location, frequency).

C. Availability of Services

1. 24-Hour Coverage

   a. The Contractor must provide a single, toll-free telephone line, available to each and every Enrollee, with 24-hours-per-day, 7-days-per-week access to an on-call skilled health-care professional who:

      1) Has immediate access to the CER (see **Section 2.4.A.9**);

      2) Is able to address the Enrollee's medical and social needs;

      3) Has the experience and knowledge to provide clinical triage; and

      4) Is able to provide options other than waiting until business hours or going to the emergency room.

   b. The Contractor must follow federal and State regulations about 24-hour service availability (for example, hospital, home health, and hospice require 24-hour availability; adult day health, homemaker, and chore services do not).

2. Triage System

   The Contractor must maintain a triage system for the management of Emergency Conditions and Urgent Care. The triage system, including the identification of the appropriate level of care, must be driven by clinically based criteria consistent with clinical research and industry standards. The clinical criteria must include protocols about the processes for access to, and communication with, appropriate PCPs or PCTs and the Enrollee’s other Providers.

3. Access to Services for Emergency Conditions and Urgent Care

   The Contractor must ensure access to 24-hour emergency services for all Enrollees, whether they reside in institutions or in the community.

   a. When service for an Emergency Condition is required, the Contractor must have a process established to notify the PCP or PCT (or the designated covering physician) within one business day after the Contractor is notified by the Provider. If the Contractor is not notified by the Provider within 10 calendar days of the Enrollee’s presentation for emergency services, the Contractor is not responsible for payments;

   b. When Urgent Care is required, the Contractor must have a process to notify the PCP

or PCT within 24 hours after the Contractor is notified;

c. Summary information about Emergency Conditions and Urgent Care services provided must be recorded in the CER no more than 18 hours after the PCP or PCT is notified, and a full report of the services provided within two business days;

d. The Contractor shall cover and pay for Emergency Services in accordance with 42 CFR 438.114 and M.G.L. c. 118E, section 17A.

e. Pursuant to 42 U.S.C. §1396u-2(b)(2) and 42 CFR 438.114, the Contractor must cover and pay for Emergency Services rendered to an Enrollee, 24-hours a day and seven days a week, regardless of prior authorization or such provider's contractual relationship with the Contractor. The Contractor shall pay a non-contracted provider of Emergency 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.

f. The Contractor shall not:

   1) Deny payment for treatment of an Emergency Medical Condition;

   2) Deny payment for treatment when a representative of the Contractor instructed the Enrollee to seek Emergency Services. Treatment obtained when an Enrollee had an emergency medical condition;

   3) Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms; or

   4) Hold an Enrollee who has an Emergency Medical Condition liable for subsequent screening and treatment needed to diagnose or stabilize the specific condition.

g. 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.

h. 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.

i. 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 such transfer or discharge order is consistent with generally accepted principles of professional medical practice.

In Massachusetts, generally accepted principles of professional medical practice for behavioral health treatment require the provider of Emergency Services to obtain for the Enrollee an ESP service to receive crisis assessment, intervention and stabilization

treatment to determine the need for appropriate Post-Stabilization Care Services, including Inpatient, Diversionary and Outpatient Services.

4. Urgent Care and Symptomatic Office Visits

   All Urgent Care and symptomatic office visits must be available to Enrollees within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention. Examples include recurrent headaches or fatigue.

5. Nonsymptomatic Office Visits

   All nonsymptomatic office visits must be available to Enrollees within 30 calendar days. Examples of nonsymptomatic office visits include, but are not limited to well and preventive-care visits for Covered Services, such as annual physical examinations or immunizations. (See **Appendix A** for a list of Covered Services.)

6. Choice of Long Term Care and Hospital Providers

   The Contractor's Provider Network must offer Enrollees access to at least two nursing facilities and two community long term care service Providers. When feasible, the Contractor's Provider Network must also offer Enrollees access to at least two hospitals.

D. Cultural and Linguistic Competence

The Contractor shall ensure that:

1. Multilingual Providers and, to the extent that such capacity exists within the Contractor's Service Area, 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 within the Contractor's Service Area;
3. 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; and
5. It participates in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

E. Access for Enrollees with Disabilities

Physical and telephone access to services must be made available for individuals with disabilities. The Contractor must reasonably accommodate persons with disabilities and

ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from the Contractor. Network providers must provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities.

F. Access to Home- and Community-Based Services

The Contractor must demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the Enrollee's place of residence when office visits are unsafe or inappropriate for the Enrollee's clinical status. Service sites must include, but not be limited to, the Enrollee's private residence, or a nursing or assisted-living facility.

G. Formulary

1. The Contractor shall make available, in electronic and paper form, the following information about its formulary:
   a. Which medications are covered (both generic and name brand);
   b. What tier each medication is on, if applicable; and
   c. Any additional information required by EOHHS and/or CMS.
2. The Contractor shall maintain the formulary required by this section in both electronic and paper form as follows:
   a. Electronic Version – The Contractor shall maintain the electronic version of its formulary on its website in a machine readable file and format.
   b. Paper Version – Upon request, the Contractor shall provide each Enrollee or Potential Enrollee a paper version of its formulary.
3. If directed by EOHHS and/or CMS, the Contractor shall report the information required in this **Section 2.6.G** using a template provided by EOHHS or CMS.

Section 2.7 Enrollee Services

A. Enrollee Service Representatives (ESRs)

The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees. ESRs must be capable of speaking directly with, or arranging for someone else to speak with, Enrollees in their primary language, or through an alternative language device or telephone translation service.

B. ESR Support Functions

ESRs must:

1. Be knowledgeable about MassHealth, Medicare, and all terms of the Contract, including the Covered Services listed in **Appendix A**; and
2. Be available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances.

C. Enrollee Service Telephone Responsiveness

ESRs must be available during normal business hours on a daily basis. The Contractor must answer 90% of all Enrollee telephone calls within 20 seconds, and be able to provide reports indicating compliance with this requirement upon request of EOHHS. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question.

D. The Contractor shall comply with federal and State (including EOHHS) requirements regarding electronic visit verification, as directed by EOHHS.

Section 2.8 Enrollee Grievances and Appeals

The Contractor shall maintain written unified policies and procedures for the filing by Enrollees or Appeal Representatives, and the receipt, timely resolution, and documentation by the Contractor, of any and all Grievances and internal Appeals in accordance with 42 CFR Part 438, Subpart F, and, effective January 1, 2021, in accordance with 42 CFR §§ 422.629 – 422.634, 438.210, 438.400, and 438.402. This includes:

1. Grievances and internal Appeals systems that meet the standards described in §422.629;
2. An integrated Grievance process that complies with §422.630;
3. A process for making integrated organization determinations (referred to here as "determinations" or "service authorizations") consistent with §422.631;
4. Continuation of benefits ("Continuing Services") while an internal Appeal is pending consistent with §422.632;
5. A process for making integrated reconsiderations consistent with §422.633 (referred to here as "internal Appeals"); and
6. A process for effectuation of decisions consistent with §422.634.

A. General Requirements

1. The Contractor shall maintain written policies and procedures for the receipt and timely resolution of Grievances and Internal Appeals. Such policies and procedures shall be approved by EOHHS.
2. The Contractor shall review the Grievance and Internal Appeals policies and procedures established pursuant to subsection 1, above, at least annually, to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS.
3. The Contractor shall create and maintain records of Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, and reviews by the CMS Independent Review Entity, using the health information system(s) specified in **Section 2.14.B**, to document:
    a. The type and nature of each Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal, and review by the CMS Independent Review Entity;
    b. How the Contractor disposed of or resolved each Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal, or review by the CMS Independent Review Entity; and
    c. What, if any, corrective action the Contractor took.
4. The Contractor shall Report to EOHHS regarding Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, and reviews by the CMS Independent Review Entity, as described in **Appendix D** 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. The Contractor shall ensure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal or review by the CMS Independent Review Entity.
6. The Contractor shall put in place a standardized process that includes:
   a. A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;
   b. 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 2.8.B.3** and **2.8.D**, below; and
   c. A means for expedited resolution of Internal Appeals, as further specified in **Section 2.8.D.4**, 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 2.8.D.1.a**, could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.
7. The Contractor shall put in a place a mechanism to:
   a. Accept Grievances at any time, whether filed either orally or in writing; and
   b. Accept internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action. If an internal Appeal is filed orally, the Contractor must send the Enrollee or Appeal Representative an acknowledgement letter to confirm the facts and basis of the internal Appeal. Internal Appeals filed later than 60 calendar days from the notice of Adverse Action may be rejected as untimely unless the enrollee shows good cause why the untimely internal Appeal should be accepted.
8. The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Enrollees and, if an Appeal Representative filed the Grievance or Internal Appeal, to the Appeal Representative and the Enrollee within one business day of receipt by the Contractor.
9. 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 2.8.B**.
10. The Contractor shall ensure that no punitive action is taken against a Provider that makes a Service Authorization Request, requests a determination, or requests an internal Appeal from the Contractor or supports an Enrollee's request for these actions.
11. The Contractor shall inform providers and subcontractors at the time they enter into a contract about BOH procedures and the Contractor's Grievance and internal Appeal system including, at a minimum, information on the Grievance, internal Appeal, external appeal, and Board of Hearing procedures and timeframes. Such information shall

include:

a. The right to file a Grievance or internal Appeal;

b. The requirements and timeframes for filing a Grievance or internal Appeal;

c. An Enrollee's right to request a fair hearing;

d. An Enrollee's right to Continuing Services; and

e. The availability of assistance in the filing process.

12. The Contractor shall accept Grievances or internal Appeals and requests for determination or service authorization from the following individual or entities, who shall be considered parties to the case:

    a. The Enrollee or his or her representative;

    b. An assignee of the Enrollee (that is, a physician or other provider who has furnished or intends to furnish a service to the Enrollee and formally agrees to waive any right to payment from the Enrollee for that service), or any other provider or entity (other than the Contractor) who has an appealable interest in the proceeding;

    c. The legal representative of a deceased Enrollee's estate; or

    d. Any provider that furnishes, or intends to furnish, services to the Enrollee. If the provider requests that the benefits continue while the appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the provider must obtain the written consent of the Enrollee to request the Appeal on behalf of the Enrollee.

13. The timeframes and notice requirements set forth in this section shall be the same for all Covered Services. Timeframe and notice requirements for Part B drugs are governed by and must comply with 42 CFR 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), and 422.590(e)(2).

14. The Contractor's failure to adhere to the notice and timing requirements regarding service authorizations, determinations, and internal Appeals shall constitute an Adverse Action for the Enrollee such that:

    a. For service authorizations and determinations, the Enrollee shall be entitled to file an internal Appeal; and

    b. For internal Appeals, the Enrollee shall be entitled to file a BOH Appeal or receive CMS Independent Review Entity pursuant to **Section 2.8.F**.

15. In the event that an Enrollee pursues an external Appeal in multiple forums and receives conflicting decisions, the Contractor is bound by and shall act in accordance with decisions most favorable to the Enrollee.

B. Notice of Adverse Action

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.B**.

2. The notice must explain the following:

a. The Adverse Action the Contractor has taken or intends to take;

b. The date on which the Contractor decided to take the Adverse Action;

c. The date on which the Adverse Action will take effect;

d. 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 process, strategies, and standards related to the Adverse Action;

e. 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;

f. The procedures for an Enrollee to exercise his/her right to file an internal Appeal;

g. The circumstances under which expedited resolution of an internal Appeal is available and how to request it; and

h. 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 review within 10 days of the notice of the Adverse Action.

3. If the service decision regards a hospital discharge of an Enrollee covered by Medicare, the notice must explain the Quality Improvement Organization (QIO) Appeal process, which is outlined in **Section 2.8.D**.

4. 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 422.631, except as provided in 42 CFR 431.213 and 431.214. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to five calendar days before the Date of Action if the Contractor has facts indicating that action should be taken because of probable fraud by the 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:

1) Failure to follow prior authorization procedures;

2) Failure to follow referral rules; and

3) 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 2.4.A.15.c**, 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:

1) 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:

      (i) The extension is in the Enrollee's interest; and

      (ii) There is a need for additional information where:

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

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

2) If the Contractor extends the timeframe, it must:

   a) Give the Enrollee written notice of the reason for the extension as expeditiously as the Enrollee's health condition requires but no later than within 2 calendar days of making the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

   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 2.4.A.15.d**, and expedited requests for determinations, as expeditiously as the Enrollee's health requires but no later than 72 hours after the receipt of the expedited request.

   1) If the Contractor denies the request for expedited authorization or determination, the Contractor shall:

      a) Automatically transfer the request to the standard timeframe and make the determination within the 14-day timeframe set forth in **Section 2.8.C.3.c**. The 14-day period begins with the day the Contractor receives the request for expedited determination.

      b) Give the Enrollee prompt oral notice of the denial and transfer and subsequently deliver, within 3 calendar days, a written notice that:

         (i) Explains that the Contractor will process the request using the 14-day timeframe for standard determinations;

         (ii) Informs the Enrollee of the right to file an expedited Grievance if the Enrollee disagrees with the decision not to expedite;

         (iii) Informs the Enrollee for the right to resubmit a request for an expedited determination with any physician's support; and

         (iv) Provides instructions about the Grievance process and its timeframes.

2) If the Contractor must receive medical information from noncontracted providers, the Contractor must request the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited determination. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the Contractor in meeting the required timeframe. Regardless of whether the Contractor must request information from noncontracted providers, the Contractor is responsible for meeting the timeframe and notice requirements of this section.

3) The Contractor may extend the timeframe for an expedited Service Authorization Request up to 14 additional calendar days. Such extension shall be implemented as follows:

a) The extension shall only be allowed if:

(i) The Provider, Enrollee or Appeal Representative requests the extension, or

(ii) The Contractor can justify (to EOHHS, upon request):

(a) The extension is in the Enrollee's interest; and

(b) There is a need for additional information where:

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

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

b) If the Contractor extends the timeframe, it must do the following:

(i) Give the Enrollee written notice of the reason for the extension as expeditiously as the Enrollee's health condition requires, but no later than the expiration of the extension, and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

(ii) 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 **Section 2.4.A.15**, 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 **Sections 2.5.A** and **2.6**, within one business day upon notification by the Enrollee or Provider that one of the access standards in **Sections 2.5.A** and **2.6** was not met.

C. Handling of Grievances and Internal Appeals

In handling Grievances and internal Appeals, the Contractor shall:

1. Inform Enrollees of the Grievance, internal Appeal, and BOH Appeal procedures.
2. Give reasonable assistance to Enrollees in completing forms, filing, 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;
3. Provide notice of Adverse Actions as specified in **Section 2.8.B**;
4. Accept Grievances and internal Appeals filed in accordance with **Section 2.8.A.7**;
5. 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;
6. Provide a reasonable opportunity for the Enrollee or an Appeal Representative to present evidence, testimony, 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 an expedited internal Appeal;
7. Provide meaningful procedures for timely hearing and resolving Grievances between Enrollees and the Contractor or any other entity or individual through which the Contractor provides covered items and services;
8. Ensure that the individuals who make decisions on Grievances and internal Appeals:
    a. 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
    b. 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.
9. Ensure that the decision-makers on Grievances and internal Appeals concerning any of the following are individuals 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 or internal Appeal:
    a. An internal Appeal of a denial that is based on lack of Medical Necessity;
    b. A Grievance regarding denial of expedited resolution of an internal Appeal; and
    c. A Grievance or internal Appeal that involves clinical issues;
10. Ensure that the following special requirements are applied to internal Appeals:
    a. The Contractor shall offer one level of review of an Adverse Action for internal Appeals;
    b. 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;
    c. 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 confirm the Appeal in writing as specified in **Section 2.8.A.7.b**, unless the Enrollee or the Provider requests expedited resolution of the Appeal;

d. The Contractor shall provide the Enrollee and Appeal Representative, before and during the internal Appeal process, the Enrollee's case file, including medical records, and any other documentation and records considered, relied upon, or generated in connection with the internal Appeal or the Contractor's determination or service authorization being appealed. This information shall be provided free of charge and sufficiently in advance of the applicable resolution timeframe.

e. 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.

D. Resolution and Notification of Grievances and Internal Appeals

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:

   a. 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

   b. 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's request for an internal Appeal, unless this timeframe is extended under **Section 2.8.D.2.b**, below;

   c. For expedited resolution of internal Appeals and notice to affected parties, no more than 72 hours after the Contractor received the expedited internal Appeal unless this timeframe is extended under **Section 2.8.D.2.b**, below. 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 or Medicare-accepted alternative. 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 for the Enrollee, as long as the expedited internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

2. Extend the timeframes specified in **Section 2.8.D.1** as follows:

   a. Extend the timeframe in **Section 2.8.D.1.a** 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 five calendar days;

b. Extend the timeframes in **Section 2.8.D.1.b** and **Section 2.8.D.1.c** for 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;

c. For any extension not requested by the Enrollee, the Contractor shall:

1) Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the delay;

2) Provide the Enrollee and Appeal Representative written notice of the reason for the delay immediately, but no later than 2 calendar days of making the decision to extend the timeframe. Such notice shall include the reason for the extension and the Enrollee's right to file a Grievance if the Enrollee disagrees with the decision to delay; and

3) Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

3. Provide notice in accordance with **Section 2.8.D.1**, above, regarding the disposition of a Grievance or the resolution of a standard or expedited internal Appeal as follows:

a. All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10. For notice of an expedited internal Appeal resolution, the Contractor must also make reasonable efforts to provide oral notice to the Enrollee; and

b. The notice shall contain, at a minimum, the following:

1) The results of the resolution process, the basis of the resolution, the date the internal review was completed, and the effective date of the internal Appeal decision;

2) For internal Appeals not resolved wholly in favor of the Enrollee:

a) The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing form, and an explanation of the CMS Independent Review Entity process; and

b) 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 on or before the later of the following:

(i) Ten (10) calendar days from the date the Contractor sent the notice of Adverse Action, unless the Enrollee specifically indicates that the Enrollee does not want to receive Continuing Services, or

(ii) The intended effective date of the Contractor's proposed Adverse Action as stated in the notice of Adverse Action.

4. Resolve expedited internal Appeals as follows:

a. The Contractor shall accept a request to expedite the internal Appeal filed by an Enrollee or a Provider on behalf of an Enrollee, submitted orally or in writing.

b. The Contractor shall resolve internal Appeals expeditiously in accordance with the timeframe specified in **Section 2.8.D.1.c**, above, 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.

c. The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support an Enrollee's internal Appeal.

d. If the Contractor denies an Enrollee's request for an expedited resolution of an internal Appeal, the Contractor shall:

1) Transfer the internal Appeal to the timeframe for standard resolution in **Section 2.8.D.1**, above. The 30-day period begins with the day the Contractor receives the request for the expedited internal Appeal; and

2) 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:

a) The reason for the denial;

b) The Enrollee's right to file a Grievance if the Enrollee disagrees with the decision not to expedite, including timeframes and procedures for filing a Grievance; and

c) The Enrollee's right to resubmit the request for an expedited determination with any physician's support.

3) Resolve the appeal as expeditiously as the Enrollee's health condition requires, and no later than the applicable deadlines set forth in this Contract.

e. 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.

f. If the Contractor must receive medical information from non-contracted providers, the Contractor must request the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited internal Appeal. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the Contractor in meeting the required timeframe. Regardless of whether the Contractor must request information from non-contracted providers, the Contractor is responsible for meeting the timeframe and notice requirements of this section.

E. Ombudsman Coordination

The Contractor shall support Enrollee access to, and work with, the Ombudsman, once available, to address Enrollee and Eligible Beneficiary requests for information, issues, or concerns related to SCO, including:

1. Educating Enrollees about the availability of Ombudsman services:
   a. At orientation;
   b. When members receive the Enrollee Handbook package;
   c. At the time of the Ongoing Assessments; and
   d. When Enrollees – or their family members or representatives – contact the Contractor, including ESR and provider staff, with a concern, Complaint, grievance or Appeal;
2. Communicating and cooperating with Ombudsman staff as needed for them to investigate and resolve Enrollee or Eligible Beneficiary requests for information, issues, or concerns related to SCO, including:
   a. Providing Ombudsman staff with access to records needed to investigate and resolve Enrollee Complaints (with the Enrollee's approval); and
   b. Ensuring ongoing communication and cooperation of Plan staff with Ombudsman staff in working to investigate and resolve Enrollee complaints, including updates on progress made towards resolution, until such time as the complaints have been resolved.

F. CMS Independent Review Entity

1. If on internal Appeal the Contractor does not decide fully in the Enrollee's favor and the Appeal is regarding a Medicare covered service, within the relevant time frame, the Contractor shall, in accordance with CMS guidelines, prepare a written explanation and forward the case file to the CMS Independent Review Entity, contracted by CMS, for a

new and impartial review within the following timeframes:

a. For standard internal Appeals, as expeditiously as the Enrollee's health condition requires, but no later than 30 calendar days from the date it received the internal Appeal (or the end of an extension pursuant to **Section 2.8.D.2**); and

b. For expedited internal Appeals, as expeditiously as the Enrollee's health condition requires, but no later than 24 hours of its affirmation (or the end of an extension pursuant to **Section 2.8.D.2**).

2. The Contractor shall make reasonable and diligent efforts to assist in gathering and forwarding information to the CMS Independent Review Entity.

3. If the CMS Independent Review Entity decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute within 72 hours from the date the Contractor receives the review entity's notice reversing the Contractor's decision, or provide the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from the date of the notice.

   a. For expedited external Appeals, the CMS Independent Review Entity will send the Enrollee and the Contractor a letter with its decision within 72 hours after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

   b. If the CMS Independent Review Entity decides in the Enrollee's favor, the Contractor must authorize or provide the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision. If the CMS Independent Review Entity reverses an Action to deny, limit, or delay services, and the Enrollee received such services while the appeal was pending, the Contractor shall pay for such services.

   c. If the Contractor or the Enrollee disagrees with the CMS Independent Review Entity's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The Contractor must comply with any requests for information or participation from such further Appeal entities.

G. BOH Appeals

If, on internal Appeal, the Contractor does not decide fully in the Enrollees' favor, and the Appeal concerns a Medicaid covered service, 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 fails to satisfy applicable notice requirements;

2. Include with any notice following the resolution of an Internal Appeal any and all instructive materials and forms provided to the Contractor by EOHHS that are required

for the 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:
      1) 120 days after the Enrollee's receipt of the Contractor's Final Internal Appeal Decision where the Contractor has reached a decision wholly or partially adverse to the Enrollee, provided however that if the Contractor did not resolve the Enrollee's Internal Appeal within the time frames specified in this Contract and described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that Internal Appeal has expired; and
      2) For all BOH Appeals in which the Enrollee wants Continuing Services that are the subject of the BOH Appeal, such request must be submitted within 10 calendar days after the notice following the Internal Appeal, as specified in **Section 2.8.D.3**.
4. At the direction of EOHHS, the Contractor shall be a party to the BOH Appeal and any subsequent actions and further levels on the Appeal, along with the Enrollee and their representative or the representative of a deceased Enrollee's estate. The Contractor shall comply with any final decision upon judicial review.

H. Hospital Discharge Appeals

1. When a Dual Eligible Enrollee is being discharged from the hospital, the Contractor must assure that the Enrollee receives a written notice of explanation required by 42 CFR §§ 422.620-622. The Enrollee has the right to request a review by a QIO of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.
2. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. Note: an Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.
3. The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.
4. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar following the day the QIO notifies the Enrollee of its decision.
5. If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

I. Continuing Services

1. The Contractor shall comply with the provisions of 42 CFR 438.420 and 42 CFR 422.632 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 the Enrollee does not want to receive Continuing Services, when all of the following conditions are met:
    a. The Appeal involves the termination, suspension, or reduction of a previously authorized service;
    b. The enrollee's services were ordered by an authorized provider; and
    c. The period covered by the original authorization has not expired.
2. The Contractor shall provide Continuing Services until one of the following occurs:
    a. The Enrollee withdraws the internal Appeal;
    b. The period covered by the original authorization has expired;
    c. The Contractor sends the notice of an adverse internal Appeal resolution; or
    d. For Appeals involving Medicaid benefits:
        1) The Enrollee does not request a BOH Appeal in a timely fashion;
        2) The Enrollee withdraws the BOH Appeal; or
        3) 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;
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; and
5. If the Contractor or BOH upholds an Adverse Action to deny, limit, or delay services:
    a. The Contractor may not pursue recovery for costs of services furnished by the Contractor pending the internal Appeal, to the extent that the services were furnished solely under the requirements of this section.
    b. If, after the internal Appeal decision is final, an Enrollee requests that Medicaid services continue through a BOH Appeal, state rules on recovery of costs, in accordance with the requirements of § 438.420(d) of this chapter, apply for costs incurred for services furnished pending appeal subsequent to the date of the integrated reconsideration decision. The Contractor may not recover the cost of services furnished to Enrollees during an external Appeal without prior EOHHS approval of such a policy and provision of advance notice to Enrollees.

J. Additional Requirements

The Contractor shall:

1. For all Internal Appeal decisions upholding an Adverse Action, in whole or in part, provide EOHHS, 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;
2. Upon learning of a hearing scheduled on a BOH Appeal concerning such an Internal Appeal, notify EOHHS immediately and include the names of the Contractor's clinical and other staff who will be attending the BOH hearing;
3. Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;
4. Submit all applicable documentation to the BOH, EOHHS, the 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 **Sections 2.8.C and 2.8.D**;
    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 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.

Section 2.9 Quality Management

In accordance with federal and State requirements, including 42 CFR 438.330, the Contractor must operate an ongoing quality management program, which includes quality assessment and performance improvement, for the services that it furnishes to its Enrollees. The Contractor must also participate in annual external quality reviews conducted by the External Quality Review Organization.

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. Effectiveness of long term services and supports in delivering person-centered services designed to maintain and restore function and avoid clinical and functional decline;
    d. Access and availability of primary and specialty health care Providers and services;
    e. Continuity and coordination of care across settings, and transitions in care; and
    f. 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.
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 Subpart E, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

The Contractor shall:

1. Ensure that the QM/QI program is informed by consistent utilization and analysis of data, incorporating at least the following elements:
    a. A process for collecting, analyzing and managing with data to improve Enrollees' health outcomes, functional status, and well-being;
    b. A process for collecting and submitting performance measurement data in accordance with 42 CFR 438.330;
    c. A process for tracking to resolution areas targeted for QI as identified by the Contractor, EOHHS or CMS;
    d. Using multiple data sources and drawing conclusions based on data to drive system improvement through evidence-based practices, practice guidelines, and other data-driven clinical initiatives.
2. 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;
3. 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;
4. Include mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs;
5. Include mechanisms to assess the quality and appropriateness of care furnished to Enrollees using long-term services and supports, including:
    a. An assessment of care between care settings;
    b. A comparison of services and supports received with those set forth in the Enrollee's treatment plan; and
    c. Alignment of the assessment, care plan and individual person-centered goals.
6. Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare) that are based on, at a minimum, the requirements for the State's home- and community-based waiver programs;
7. 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 2.9** 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;

8. 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;

9. Submit to EOHHS an annual QM/QI Work Plan, in accordance with **Appendix L**, that shall include 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 2.5.c.1.b** and the results of Network Provider satisfaction surveys as described in **Section 2.9.B.7.c** above;

10. 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.

C. QM/QI Activities

1. Annual Performance Improvement Projects

   a. The Contractor must annually develop at least two specific Performance Improvement Projects in the areas of integration of Primary Care, long term care, and behavioral health or areas that involve the implementation of interventions to achieve improvement in the access to and quality of care. The Contractor must provide documentation on each project, describing:

      1) The problem to be addressed by the project;

      2) The rationale;

      3) How performance will be measured, using objective quality indicators;

      4) The target population;

      5) The method of evaluating performance;

      6) How findings will be documented;

      7) How recommendations will be developed and implemented; and

      8) An evaluation of the effectiveness of the interventions based on the performance measures collected as part of the Performance Improvement Project.

2. Quality Management Resources

   The Contractor must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. The following must be available:

   a. Quality Management Director

      An identified senior-level director who will oversee all quality management and performance-improvement activities. The quality management director must have expertise in the Geriatric Model of Care.

   b. Medical Director

      A medical director licensed by the Massachusetts Board of Registration in Medicine with geriatric expertise and experience in community and institutional long-term care, who will be responsible for establishing medical protocols and practice guidelines to support the program initiatives in **Section 2.9.C.3** below.

c. Geriatrician

A qualified geriatrician, licensed by the Massachusetts Board of Registration in Medicine and further certified in Geriatric Medicine, who will be responsible for establishing and monitoring the implementation and administration of geriatric management protocols to support a geriatric model of practice. The medical director may also serve as the Geriatrician if they meet the requirements.

d. Behavioral Health Clinician

A qualified behavioral health clinician, with expertise in geriatric service, who will be responsible for establishing behavioral health protocols and providing specialized support to PCPs and PCTs.

3. Program Initiatives

a. Initiative to Reduce Preventable Hospital Admissions

The Contractor must have and comply with written protocols to minimize unnecessary or inappropriate hospital admissions and a reporting system to record all preventable hospital admissions. The protocols must include at least the following:

1) Monitoring and risk-assessment mechanisms, which are operative on a continuous basis, to identify Enrollees at-risk of hospitalization for at least the following conditions or profiles: pneumonia, dehydration, injuries from falls, skin breakdown, loss of informal caregiver, and history of noncompliance with treatment programs;

2) Processes that link the Initial and Ongoing Assessments to the timely provision of appropriate preventive care and other treatment interventions to at-risk Enrollees. Such processes must emphasize continuity of care and coordination of services and must be in accordance with accepted clinical practice. The Contractor must perform outcome analyses to evaluate the effectiveness of the protocols; and

3) Formal linkages among the PCP, PCT, and Providers (specialty, long term care, and behavioral health) through the CER and other mechanisms, that must be used to provide timely information to the Contractor's Provider Network, in order to implement early interventions for Enrollees and prevent hospitalizations.

b. Discharge Planning Initiative

The Contractor must have and comply with written protocols and a reporting system to record discharge activities to ensure that Enrollees who are admitted to an institution receive the following:

1) Interdisciplinary Discharge Planning and implementation processes that begin at the point of admission to the hospital or nursing facility;

2) Person-centered planning that includes involvement of the Enrollee, and if applicable, the GSSC, the Providers of home- and community-based services,

and the Enrollee's designated representative, in determining which discharge setting is appropriate; and

3) Person-centered planning that includes care planning and arranging for services, Providers, and equipment that will be needed upon discharge.

c. Preventive Immunization(s)

The Contractor must have and comply with written protocols to provide pneumococcal vaccine and timely annual influenza immunizations and other relevant vaccines, as recommended by the Centers for Disease Control (CDC), and a reporting system to record all immunizations given. The protocols must include the following components:

1) Development and distribution of Contractor and PCP/PCT practice guidelines and measurement of PCP/PCT compliance with the guidelines;

2) Educational Outreach to Enrollees and caregivers about appropriate preventive immunization schedules; and

3) Prompt access to immunizations for ambulatory, homebound, and institutionalized Enrollees.

d. Screening for Early Identification of Cancer

The Contractor must have and comply with written protocols to provide cancer-screening services, and the provision of appropriate follow-up services. The Contractor must develop a reporting system to record all tests given, positive findings, and actions taken to provide appropriate follow-up care. The protocols must include the following components:

1) Written practice guidelines developed in accordance with accepted clinical practice, provided to all PCP/PCTs, with compliance measured at least annually;

2) Education Outreach to both Enrollees and caregivers about preventive cancer-screening services; and

3) Cancer screening recommendations as designated by the U.S. Preventative Task Force.

e. Disease Management

The Contractor must have and comply with written protocols to manage the care for Enrollees identified with congestive heart failure, chronic obstructive pulmonary disease, diabetes, and depression and a reporting system that produces clinical indicator data as required in **Section 2.14.A.2**. The protocols must include the following:

1) Written practice guidelines, in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards;

2) Measurement and distribution of reports relating to Contractor and PCP/PCT compliance with practice guidelines;

3) Educational programming for Enrollees and caregivers that emphasizes self-care and maximum independence;

4) Formal educational processes for clinical Providers in the best practices of managing the disease; and

5) Evaluation of effectiveness of each program by measuring outcomes of care.

f. Management of Dementia

The Contractor must have and comply with written protocols to identify dementia and its stage, manage the care for Enrollees identified with dementia and a reporting system that produces clinical indicator data. The protocols must include the following:

1) Written practice guidelines and trainings in accordance with accepted clinical practice, including diagnostic, pharmacological, and functional standards, with evaluation of the effectiveness of these protocols on outcomes of care and management of disease progression;

2) Measurement and distribution of reports relating to compliance with practice guidelines;

3) Educational programming for significant caregivers that emphasizes community-based care and support systems for caregivers; and

4) Formal educational process for clinical Providers in the best practices of managing dementia.

g. Appropriate Nursing Facility Institutionalization

The Contractor must have and comply with written protocols for nursing facility admissions and report institutional utilization data. The protocols must include the following activities:

1) Identify medical conditions and patient profiles that differentiate between Enrollees at risk of being institutionalized and those who require institutional care;

2) Develop monitoring and risk-assessment mechanisms that assist the PCP or PCT to identify Enrollees at risk of institutionalization;

3) Implement processes that link Initial and Ongoing Assessments to the timely provision of appropriate preventive care and treatment interventions to at-risk Enrollees. Such protocols must emphasize continuity of care and coordination of services. The protocols must be based upon an evaluation of the outcomes and costs of care;

4) Implement processes to ensure the timely provision of nursing facility services when necessary;

5) Identify and formalize the linkages present between the PCPs, PCTs, the long term care Providers of home- and community-based services, and informal supports (e.g. unpaid caregivers) and how these linkages encourage and support maintaining Enrollees in their communities as long as appropriate; and

6) For individuals who can safely and adequately be cared for in the community, implement a Discharge Planning program that begins at the point of admission to any institution, to ensure the earliest appropriate discharge to community long term care.

h. Substance Abuse Prevention and Treatment Initiative

The Contractor must have and comply with written protocols to prevent, identify, and treat substance abuse and a reporting system that produces utilization data. Protocols must include the following:

1) Written practice guidelines, in accordance with accepted clinical guidelines, to treat substance abuse and evaluate the effectiveness of the treatment;

2) Distribution of the practice guidelines and measurement of compliance with the practice guidelines on the part of the Contractor, the PCPs, and any PCTs;

3) Procedures for identifying Enrollees who are currently abusing substances including narcotics and alcohol or at risk for abuse; and

4) Documentation of coordination between the PCP or PCT and the behavioral health Provider.

i. Abuse, Neglect, and Exploitation Identification Initiative

The Contractor is a mandated reporter of elder abuse under State law. The Contractor must submit to EOHHS Incident Reports that document all alleged incidents of abuse, neglect and exploitation of an Enrollee and all actions taken by the Contractor in response to those alleged incidents. In addition, the Contractor must have and comply with written protocols to prevent and treat abuse, neglect, and exploitation of Enrollees. Protocols must include the following:

1) Diagnostic tools, in accordance with accepted clinical practice, for identifying Enrollees who are experiencing, or who are at risk of, abuse, neglect and exploitation;

2) Written practice guidelines to treat abuse, neglect, and exploitation of Enrollees and evaluate effectiveness of interventions;

3) Distribution of the practice guidelines and measurement of compliance with the practice guidelines on the part of the Contractor, the PCPs, and any PCTs; and

4) Documentation of coordination between the PCP or PCT and protective service Providers.

4. Assessment of New Medical Technology

   The Contractor must maintain policies and procedures to evaluate the use of new medical technologies or new applications of established technologies including medical procedures, drugs, and devices specifically appropriate and effective for the geriatric population. The criteria and evaluation methods used in this process must be based on scientific evidence. Enrollee rights must be protected in accordance with **Appendix B**.

5. Consumer Assessment of Healthcare Providers and Services (CAHPS)

   The Contractor must conduct, as directed by EOHHS, an annual SCO-level (as opposed to Contractor-level) CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor and report CAHPS data to EOHHS annually on the anniversary of the start date of this Contract. Such SCO-level CAHPS survey shall include supplemental questions as directed by EOHHS.

6. Ethics Committee

   The Contractor must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including end-of-life issues and advance directives.

7. Electronic Visit Verification Initiative

   The Contractor must cooperate with the EOHHS on development and future implementation of Electronic Visit Verification (EVV) and ensure that SCO EVV systems comply with the requirements outlined in Section 12006 of the 21st Century Cures Act (codified as 42 USC 1396b(l)) and as directed by EOHHS.

8. Serious Reportable Events

   The Contractor shall cooperate with EOHHS in developing and implementing a process for ensuring non-payment for services constituting or resulting from so-called serious reportable events, as defined by the National Quality Forum.

9. Long-Term Services and Supports Advisory Committee

   Pursuant to 42 CFR 438.110, the Contractor must establish and maintain a long-term services and supports member advisory committee. At a minimum, this committee must include a reasonably representative sample of the Enrollees receiving long-term services and supports under this Contract, or their representatives.

10. 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.

11. The Contractor will participate with EOHHS in the ongoing development and adoption of

quality measures specifically related to delivery by the Contractor of long-term services and supports.

12. According to the timeframes established in **Appendix L**, the Contractor must provide EOHHS with reports on progress toward reaching established Quality Management Goals.

Section 2.10 Outreach Standards

A. General Outreach Requirements

The Contractor shall:

1. Submit to EOHHS an annual comprehensive Outreach plan on January 1 for the upcoming calendar year including proposed approaches to groups and individuals representing the cultural diversity of the Contractor's Service Area;
2. Obtain EOHHS approval of the Outreach plan and materials, before conducting any Outreach activities or distributing such materials;
3. Ensure that Outreach materials accurately reflect the Contractor's Provider Network and services offered and do not include false, misleading, or inaccurate information;
4. Refer Enrollees and Potential Enrollees who inquire about MassHealth eligibility or enrollment to EOHHS;
5. Make available to EOHHS and CMS, upon request, current schedules of all activities initiated or promoted by the Contractor to provide information or to encourage enrollment; and
6. Convene all promotional events at sites within the Contractor's Service Area that are physically accessible to all Consumers (for example, to those in wheelchairs and those using public transportation).
7. Communicate with Enrollees to help them renew their MassHealth coverage. The Contractor is authorized and directed to make appropriate use of prerecorded or artificial autodialed calls and automated texts in compliance with the Federal Communications Commission January 23, 2023, Declaratory Ruling. The Contractor shall consult its legal counsel about the appropriate use of autodialed calls and automated texts to Enrollees pursuant to the FCC Declaratory Ruling. The Contractor shall be responsible for complying with the ruling.

B. Requirements for Outreach and Enrollee Materials

The Contractor must:

1. Submit to EOHHS all forms of all Outreach and Enrollee materials, including non-English Outreach materials along with an English translation, an attestation from a certified translation agency, and a signature of the SCO Director, for review and approval before use or distribution. EOHHS must also approve any changes or updates to Outreach materials before use or distribution. Such materials include, but are not limited to:
    a. Outreach and education materials;
    b. Orientation materials;
    c. Enrollment and disenrollment materials;
    d. Benefit coverage information; and
    e. Operational letters for enrollment, disenrollment, claims, service denials, Grievances, Appeals, transitions of care, and Provider terminations.

2. Ensure that all information provided to Enrollees and Potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood. At a minimum, all written materials must:
    a. Be written in large print (at least 12 point), including any footnotes and subscript annotations;
    b. Include a large print tagline (i.e., no smaller than 18 point font size);
    c. Be translated in the Prevalent Languages used in the Service Area. If EOHHS notifies the Contractor that Prevalent Languages shall include additional languages, the Contractor shall submit a work plan to EOHHS within 60 days of the notice and shall comply with the work plan, as approved by EOHHS;
    d. Be distributed throughout the entire Service Area;
    e. Be produced in a manner, format, and language that may be easily understood and be readily accessible by Enrollees and Potential Enrollees with limited English proficiency or literacy;
    f. Be Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor's membership;
    g. Be made available in Alternative Formats in an appropriate manner that takes into consideration the special needs of those Enrollees or Potential Enrollees who have disabilities or limited English proficiency at no cost. Such written materials must also include taglines in the Prevalent Languages used in the State, as well as large print, explaining how to request auxiliary aids and services, including materials in Alternative Formats;
    h. Include a notice which explains that the enclosed materials are important and should be translated immediately, and provides information on how the Enrollee may obtain help with getting written translation or oral interpretation services at no cost. This notice shall:
        1) Be written in large print in all Prevalent Languages, as well as Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian and Vietnamese, and other languages as directed by EOHHS;
        2) Explain that oral interpretation services are available for any language at no cost, which notice shall explain how to access those services;
        3) Written translation services are available for any Prevalent Language at no cost, which notice shall explain how to access those services;
3. Have in place mechanisms to help Enrollees and Potential Enrollees understand the requirements and benefits of the Contractor's plan;
4. Not be provided electronically unless all of the following are met:
    a. The format is readily accessible;
    b. The information is placed in a location on the Contractor's web site that is prominent and readily accessible;

c. The information is provided in an electronic form which can be electronically retained and printed;

d. The information is consistent with the content and language requirements of this Contract; and

e. The 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.

5. Ensure that all pre-enrollment and disenrollment materials include a statement that the Contractor's plan is a voluntary MassHealth benefit in association with EOHHS and CMS;

6. Have the following information available upon the request of an Enrollee or Potential Enrollee:

   a. A clear, comprehensive description of the Contractor's plan including all enrollment requirements;

   b. Detailed information about the Covered Services;

   c. A description of the options Enrollees and Potential Enrollees have to enroll, disenroll, and transfer on a monthly basis;

   d. A directory of all Providers in the Contractor's Provider Network;

   e. Information on the Enrollee's right to file a Grievance or Appeal; and

   f. Transition of care policies, specified in **Section 2.3.I**.

7. Develop, using a model to be provided by EOHHS to the Contractor, an Enrollee handbook, which serves as a summary of benefits and coverage.

   a. At a minimum, this handbook shall contain all of the information required by 42 CFR 438.10(g), including:

      1) The benefits provided by the Contractor;

      2) How to access Covered Services, including the amount, duration and scope of 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 the Contractor's toll-free telephone line(s), authorization requirements, information regarding applicable access and availability standards, any cost sharing, self-referral, and referral by family members or guardians, a Provider, PCP, or community agency;

      3) How to access non-Covered Services, including any cost sharing, if applicable, and how transportation to such services may be requested. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the handbook must inform Enrollees that the service is not covered by the Contractor and how they can obtain information from EOHHS about how to access those services;

      4) The process of selecting and changing the Enrollee's PCP;

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

6) The Covered Services that do not require authorization or a referral from the Enrollee's PCP;

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

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

9) An explanation that the Contractor cannot require an Enrollee to obtain a referral before choosing a family planning provider;

10) How to obtain information about Network Providers;

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

    a) What constitutes an Emergency Medical Condition, Emergency Services, and Post stabilization 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) Information regarding 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 and how to access written materials in those formats and the availability of auxiliary aids and services;

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

19) The rights and responsibilities of Enrollees, including the Enrollee's right to:

    a) Receive information on beneficiary and plan information;

    b) Be treated with respect and with due consideration for his or her dignity and privacy;

    c) Receive information on available treatment and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

    d) Participate in decisions regarding his or her health care, including the right to refuse treatment;

    e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

    f) Request and receive a copy of his or her medical records and request that such records be amended or corrected; and

    g) Obtain available and accessible health care services covered under this Contract.

20) 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, Covered Services will continue to be provided if 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;

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

j) The availability of the ombudsman.

21) Information on advance directives in accordance with **Section 5.5.E**;

22) Information on the access standards specified in **Section 2.5.A** and **2.6**;

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

24) Transition of care policies, specified in **Section 2.3.I**; and

25) Any other information required by EOHHS.

b. The Contractor shall distribute this handbook to each Enrollee as follows:

1) For each existing Enrollee, the Contractor shall:

a) Mail a printed copy of the handbook to the Enrollee at his or her mailing address;

b) Provide an electronic copy of the handbook by electronic mail after obtaining the Enrollee's agreement to receive the information by electronic mail;

c) Post the handbook on its website and advise the Enrollee, in both paper and electronic form, that the handbook is available on the internet, including the appropriate URL, provided that Enrollees with disabilities who cannot access the handbook online are provided auxiliary aids and services upon request at no cost; or

d) Provide the handbook by any other method that can reasonably be expected to result in the Enrollee receiving the information contained in the handbook.

2) For new Enrollees, the Contractor shall, within 10 days after receiving notice of the Member's enrollment with the Contractor, or by the last day of the month prior to the effective date, whichever is later, distribute the handbook in accordance with **Section 2.10.B.7.b.1**.

8. Develop Enrollee notices using models to be provided by EOHHS to the Contractor.
9. Adopt definitions as specified by EOHHS, consistent with 42 CFR 438.10(c)(4)(i):

C. Optional Outreach Activities

The Contractor may:

1. Post written Outreach and promotional materials approved by CMS and EOHHS at Contractor Provider Network sites and other sites throughout the Service Area of the Contractor;
2. Access television, radio, electronic media and printed media, including free newspapers, for the purpose of Outreach or promotion in accordance with the

requirements set forth in this Contract. All text, scripts, and materials developed by the Contractor for this purpose require review and approval by CMS and EOHHS before use;

3. Distribute approved Outreach and promotional materials by mail to Potential Enrollees, provided that the Contractor distributes such materials throughout the Contractor's entire Service Area;
4. Provide nonfinancial promotional items only if they are offered to everyone who attends the event, regardless of whether or not they enroll with the Contractor, and only if the items are of a retail value of $15.00 or less; and
5. Conduct nursing facility visits and home visits for interested seniors only if the Contractor has documented a request to visit by a senior, a caregiver, or a responsible party.

D. Prohibited Outreach Activities

The Contractor may not:

1. Offer financial or other incentives to induce Consumers to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor;
2. Directly or indirectly engage in any door-to-door, telephone, e-mail, texting, or other unsolicited or "cold-call" marketing activities;
3. Make any statements, whether written or oral, that is inaccurate, misleading, confusing, or could defraud EOHHS or any MassHealth Member. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement, whether written or oral, that:
   a. The Contractor is endorsed by CMS, the federal or state government, or similar entity; or
   b. A MassHealth Member must enroll with the Contractor to obtain benefits or to not lose benefits.
4. Seek to influence a Potential Enrollee's enrollment with the Contractor in conjunction with the sale or offering of any private insurance.

Section 2.11 Financial Requirements

A. Financial Viability

1. Minimum Net Worth

   The Contractor must have and maintain at all times a net worth that meets the minimum net worth requirements as follows:

   a. Prior to entering into this Contract, net worth shall be at least $1,000,000.

   b. Throughout the term on this Contract, the Contractor must maintain a minimum net worth of $1,000,000 subject to the following conditions:

      1) At least $500,000 of the minimum net worth amount must be maintained in cash;

      2) The Contractor may include 100% of the book value (the depreciated value according to generally accepted accounting principles (GAAP)) of tangible health care delivery assets carried on its balance sheet;

      3) If at least $800,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 20% of the minimum net worth required will be allowed; and

      4) If less than $800,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 10% of the minimum net worth required will be allowed.

   c. Determination of Net Worth

      Net worth must be determined in accordance with generally accepted accounting principles (GAAP) and reported on a quarterly basis to EOHHS in accordance with **Appendix D**. The Contractor shall make available to EOHHS, upon the request of EOHHS at any time during the term of the Contract, documentation sufficient to enable EOHHS to verify or otherwise calculate the net worth of the Contractor.

2. Working Capital Requirements

   Throughout the term of this Contract, the Contractor must demonstrate and maintain a positive working capital, subject to the following conditions:

   a. If a Contractor's working capital falls below zero, the Contractor must submit a written plan to reestablish a positive working capital balance for approval by EOHHS.

   b. EOHHS may take any action they deem appropriate, including termination of the Contract, if the Contractor:

      1) Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time;

      2) Violates a corrective plan approved by EOHHS; or

3) EOHHS determine that negative working capital cannot be corrected within a reasonable time.

c. Determination of Working Capital

Working capital must be determined in accordance with generally accepted accounting principles (GAAP) and reported on a quarterly basis to EOHHS in accordance with **Appendix D**. The Contractor shall make available to EOHHS, upon the request of EOHHS at any time during the term of the Contract, documentation sufficient to enable EOHHS to verify or otherwise calculate the working capital of the Contractor.

B. Financial Stability

1. Financial Stability Plan

a. Throughout the term of this Contract, the Contractor must:

1) Remain financially stable;

2) Maintain adequate protection against insolvency in an amount determined by EOHHS, as follows:

a) Provide to Enrollees all Covered Services required by this Contract for a period of at least 45 calendar days following the date of insolvency or until written approval to cease providing such services is received from EOHHS, whichever comes sooner;

b) Continue to provide all such services to Enrollees who are receiving inpatient services at the date of insolvency until the date of their discharge or written approval to cease providing such services is received from EOHHS, whichever comes sooner; and

c) Guarantee that Enrollees and EOHHS do not incur liability for payment of any expense that is the legal obligation of the Contractor, any of its Subcontractors, or other entities that have provided services to Enrollees at the direction of the Contractor or its Subcontractors.

3) Immediately notify EOHHS when the Contractor has reason to consider insolvency or otherwise has reason to believe it or any Subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the Contractor's board of the potential for insolvency; and

4) Maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any Provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance.

2. Insolvency Reserve

a. The Insolvency Reserve shall be defined as the funding resources available to meet

costs of providing services to Enrollees for a period of 45 days in the event that the Contractor is determined insolvent.

b. EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within 45 days of the start of the Contract Year.

c. The Insolvency Reserve calculation shall be an amount equal to 45 days of the Contractor's estimated medical expenses, not to exceed 88% of the calculated value of 45 days of capitation payment revenue.

d. Subject to EOHHS approval, the Contractor may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; net worth of the Contractor (exclusive of any restricted cash reserves); performance guarantee as specified in **Section 2.11.B.3**; insolvency insurance or reinsurance; performance bonds; irrevocable letter of credit; and other letters of credit.

3. Performance Guarantees and Additional Security

Throughout the term of this Contract, the Contractor must provide EOHHS with performance guarantees that are subject to prior review and approval from EOHHS. Performance guarantees must meet the following requirements:

a. A promissory note from the Contractor's parent(s)/affiliate or a performance bond from an independent agent in the amount of $1,000,000 to guarantee performance of the Contractor's obligation to provide Covered Services in the event of the Contractor's impending or actual insolvency; and

b. A promissory note from the Contractor's parent(s)/affiliate or a performance bond from an independent agent in the amount of $400,000 to guarantee performance of the Contractor's obligations to perform activities related to the administration of the Contract in the event of the Contractor's impending or actual insolvency.

C. Additional Financial Requirements

1. Auditing and Financial Changes

Throughout the term of this Contract, the Contractor must:

a. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits must comply with the following requirements and must be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles and generally accepted auditing standards:

1) No later than 120 days after the Contractor's fiscal year end, the Contractor shall submit to EOHHS its most recent year-end audited financial statements (balance sheet, statement of revenues and expenses, source and use of funds statement and statement of cash flows that include appropriate footnotes).

2) The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS an attestation report from its independent auditor on the effectiveness of the internal controls over operations

of the Contractor related to this Contract in accordance with statements and standards for attestation engagements as promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report; provided, however, if the Contractor is Service Organization Control (SOC) compliant, the Contractor shall annually submit a copy of the SOC report in lieu of the attestation report described above within 30 days of the Contractor's independent auditors issuing its SOC report.

3) The Contractor shall submit, on an annual basis after each annual audit, the final audit report together with all supporting documentation, a representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

b. Report annually, or more frequently when requested by EOHHS, on any significant deficiencies in internal controls as follows:

1) Furnish EOHHS with a written report prepared by the independent auditor that performed the Contractor's independent financial audit, describing significant deficiencies in the Contractor's internal control structure noted by the accountant during the audit. No report need be issued if the accountant does not identify significant deficiencies; and

2) Describe in writing the remedial actions it has taken or proposes to take to correct significant deficiencies, if such actions are not described in the accountant's report. EOHHS may require the Contractor to take additional or different corrective action to correct such deficiencies.

c. Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency;

d. 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;

e. Advise EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new contracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract; and

f. Refrain from investing funds in, or loaning funds to, any organization in which a director or principal officer of the Contractor has an interest.

2. Risk Arrangements

The Contractor may maintain Provider risk arrangements. The Contractor must disclose these arrangements to EOHHS as follows.

a. The Contractor must provide a description of any changes in its risk arrangements with all 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.

b. Any incentive arrangements must not include any specific payment as an inducement to withhold, limit, or reduce services to Enrollees.

c. The Contractor must monitor such arrangements, in accordance with the standards of EOHHS and CMS for quality of care, to ensure that medically appropriate Covered Services are not withheld.

3. Value Based Purchasing Arrangements

EOHHS encourages Contractor to enter into value based payment arrangement. If the Contractor elects to contract with their Providers, Subcontractors or suppliers under a value based purchasing arrangement, it must disclose those arrangements to EOHHS.

4. Physician Incentive Plans

a. The Contractor may, in its discretion, operate a physician incentive plan only if:

1) No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

2) No specific payment is made directly or indirectly under the plan to a Provider, physician, or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

3) The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 CFR 417 are met.

b. The Contractor and its Subcontractors must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR 438.3(i) and 42 CFR 438.6(b)(2). The Contractor must submit all information required to be disclosed to EOHHS and CMS in the manner and format specified by EOHHS and CMS, which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts and 42 CFR 422.208 and 42 CFR 422.210. The Contractor must provide information on its physician incentive plan to any Enrollee upon request. If the Contractor is required to conduct a beneficiary survey, survey results must be disclosed to EOHHS and to any Enrollee upon request.

c. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the Commonwealth that results from the Contractor's or its Subcontractors' failure to comply with the requirements governing physician incentive plans at 42 U.S.C. § 1396b(m)(2)(A)(x), 42 CFR Parts 417, 422, 434, 438, and 1003; 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 and CMS, that it has made a good faith effort to comply with the cited requirements.

5. Right to Audit and Inspect Books

   The Contractor must grant EOHHS the right to audit and inspect its books and records related to:

   a. The Contractor's capacity to bear the risk of potential financial losses; and
   b. Services performed or the determination of amounts payable under the Contract.

6. Other Information

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

7. Reporting

   To demonstrate that the Contractor has met the requirements of this **Section 2.11**, the Contractor must submit to EOHHS all required financial reports, as described in this **Section 2.11** and **Appendix D**, in accordance with specified timetables, definitions, formats, assumptions, and certifications, as well as any additional financial reports as requested by EOHHS.

8. Financial Responsibility for Post-Stabilization Services

   The Contractor must pay for post-stabilization services in accordance with 42 CFR 438.114(b) and (e), and 42 CFR 422.113(c)(2) and (3).

9. 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 USC1395i-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 2.12 Data Submissions, Reporting Requirements, and Surveys

A. General Requirements for Data

1. The Contractor must provide and require its Subcontractors to provide any and all information EOHHS requires under the Contract related to the performance of the Contractor's responsibilities.;
2. The Contractor must provide and require its Subcontractors to provide any and all information EOHHS requires in order to comply with the Balanced Budget Act of 1997, or any other federal or State laws and regulations, including, but not limited to, all data, information, and documentation required pursuant to 42 CFR 438.604.
3. The Contractor must provide and require its Subcontractors to provide EOHHS any and all data to meet all applicable federal and state reporting requirements within the legally required time frames.
4. The Contractor shall collect from its PCM Agencies, and provide to EOHHS upon request, reports as directed by EOHHS. Such reports may include, but are not limited to, the following information:
    a. The number of overtime approval requests received; and
    b. The number of overtime approval requests submitted to MassHealth.

B. General Reporting Requirements

The Contractor must:

1. Be responsible for all administrative costs associated with the development, production, mailing, and delivery of all reports required under the Contract;
2. Submit all required reports in accordance with the specifications, templates, and time frames described in this Contract and **Appendix D**, unless otherwise directed or agreed to by EOHHS. The Contractor must submit all proposed modifications, revisions, or enhancements to any reports to EOHHS for approval prior to making such changes;
3. If EOHHS does not approve any report the Contractor submits, correct or modify the report as directed by EOHHS and resubmit it to EOHHS for final acceptance and approval within time frames prescribed by EOHHS;
4. At request of EOHHS provide additional ad hoc or periodic reports or analyses of data related to the Contract, according to a schedule and format specified and prescribed by EOHHS;
5. Have the capacity to display data graphically, in tables, and in charts, as directed by EOHHS;
6. Apply generally accepted principles of statistical analysis and tests for statistical significance, as appropriate, to data contained in reports;
7. Ensure that all reports are identified with a cover page that includes at least the following information:
    a. Title of the report;

b. Production date of the report;

c. Contact person for questions regarding the report;

d. Data sources for the report;

e. Reporting interval;

f. Date range covered by the report; and

g. Methodology employed to develop the information for the report;

8. Provide with each report a narrative summary of the findings contained in the report, analyses, and actions taken or planned next steps related to those findings;

9. Submit each report electronically in a format and media compatible with EOHHS software and hardware requirements. At the request of EOHHS, also provide an original and printed copy of each report that is:

   a. In a loose-leaf binder;

   b. Clearly labeled with the titles of the reports it contains; and

   c. Has clear separations between reports when more than one report is contained in one binder.

10. Provide EOHHS with reports and necessary data to meet all applicable federal and State reporting requirements within the legally required time frames;

11. 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); and

12. Provide reports to EOHHS according to the following timetable, unless otherwise specified or approved by EOHHS. All references to “annual” or “year-to-date” reports or data refer to the Contract Year, unless otherwise specified. EOHHS may at its sole discretion assess financial penalties as described in **Section 5.5.Q** for failure to perform any reporting requirements.

   a. Incident Reports – deliver incident reports to EOHHS by 5:00 p.m. (Eastern Time) on the next business day after the Contractor receives incident notification, in accordance with the established protocol.

   b. Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported, if the 20th of the month falls on a non-business day, the next business day; except for October, January, April, and July, when monthly reports may be submitted with the quarterly reports filed in accordance with **Section 2.12.B.12.c.1**.

   c. Quarterly Reports –

      1) Except for the quarterly reports specified in **Section 2.11** of this Contract, all quarterly reports are due no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, that is, October 30, January 30, April 30, and July 30; or, if the 30th of the month falls on a non-business day, the next

business day. Quarterly reports due January 30 and July 30 may be submitted with semiannual reports.

2) For the quarterly reports specified in **Section 2.11** of this Contract, those reports are due no later than 5:00 p.m. on the 60th day following the end of the quarter reported, that is November 28, March 1, May 30 and August 29; or if the due date falls on a non-business day, the next business day.

d. Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, that is, January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day.

e. Annual Reports – April 30 or, if April 30 falls on a non-business day, the next business day.

f. One-time, Periodic, and Ad Hoc Reports – no later than the time stated, or as directed by EOHHS.

C. Participation in Surveys

The Contractor agrees to participate in any surveys required by EOHHS and to submit all information requested by EOHHS to administer and evaluate the program. This survey information regarding the Contractor must include, but not be limited to:

1. Plan quality and performance indicators, including:
   a. Information on Enrollee satisfaction;
   b. The availability, accessibility, and acceptability of services; and
   c. Information on health outcomes and other performance measures.
2. Information about Enrollee Appeals and their disposition; and
3. Information regarding formal actions, reviews, findings, or other similar actions by any governmental body, or any certifying or accrediting organization.

D. Certification Requirements

1. In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit a certification to EOHHS, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of his or her knowledge, information and belief, after reasonable inquiry:
   a. Data on which payments to the Contractor are based, including data on the basis of which the State certifies the actuarial soundness of capitation rates paid to the Contractor;
   b. All enrollment information, encounter data, and measurement data;
   c. Data related to medical loss ratio requirements;
   d. Data or information related to protection against the risk of insolvency, including the data on the basis of which the State determines that the Contractor has made

adequate provision against the risk of insolvency;

e. Documentation related to the Contractor's compliance with the requirements regarding availability and accessibility of services, including, but not limited to, annual documentation demonstrating that the Contractor's Provider Network complies with **Section 2.6.B** of this Contract.

f. Information on ownership and control, such as that pursuant to **Section 5.1.F**;

g. Reports related to overpayments; and

h. Data and other information required by EOHHS including, but not limited to, reports and data described in this Contract.

2. The Contractor must submit the certification concurrently with the certified data.

Section 2.13 Required Program Reports

A. Clinical Indicator Data

1. The Contractor must report clinical indicator data for all Enrollees in accordance with the specific HEDIS measures developed for Medicare Advantage Special Needs Plans (SNPs) by the National Commission on Quality Assurance (NCQA). The Contractor must comply with, and report to EOHHS, the HEDIS SNP Measures as required and approved by NCQA and CMS and report to EOHHS on the same time schedule required by CMS.
2. The HEDIS and other measures in **Appendix L, Exhibit 1** must be collected according to HEDIS specifications or other specifications as specified by EOHHS, and reported to EOHHS with the annual reports, unless CMS requires submission of those materials on a different time schedule.

B. Encounter Data

The Contractor shall meet any diagnosis and/or encounter reporting requirements that are mandated by federal or state law, or by EOHHS. This includes the requirements set forth in 42 CFR 438.242(c)(1)-(4), 42 CFR 438.604(a)(1) and 42 CFR 438.818. This also includes the diagnosis and/or encounter reporting requirements that apply to Medicare Advantage plans and Medicaid managed care organizations, as well as the EOHHS Encounter data specifications set forth in **Appendix I**, as may be amended from time to time. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this section.

1. The Contractor shall collect and maintain 100% Encounter Data for all Covered Services provided to Enrollees, including from any sub capitated sources. Such data must be able to be linked to MassHealth eligibility data.
2. The Contractor shall 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, the Contractor shall 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. The Contractor shall 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 I**, 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. The Contractor shall 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 to EOHHS 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 I**.
6. The Contractor shall submit Encounter Data that is at a minimum compliant with the standards specified in **Appendix O**, including but not limited to standards for completeness and accuracy. To meet the completeness standard, all critical fields in the data must contain, at a minimum, valid values. To meet the accuracy standard, the Contractor must have systems in place to monitor and audit claims. The Contractor must also correct and resubmit voided and denied encounters as necessary.
7. If EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not compliant with the benchmarks described in **Appendix O**, 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 benchmarks described in **Appendix O**. The Contractor may be financially liable for such validation study.
8. The Contractor shall 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.
9. The Contractor shall 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 I**.
10. 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.

11. At EOHHS' request, the Contractor shall submit denied claims, as further specified by EOHHS.
12. EOHHS may impose intermediate sanctions in accordance with **Section 5.5.Q** based on the completeness, accuracy, timeliness, form, format, and other standards described in this Section. 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. Consumer Assessment of Healthcare Providers and Services (CAHPS) Data

The Contractor must submit the Consumer Assessment of Healthcare Providers and Services (CAHPS) data to EOHHS annually, on the anniversary of the start date of the Contract.

D. Grievances and Appeals

1. On a monthly basis, the Contractor must report the number and types of Grievances filed by Enrollees and received by the Contractor, specifying how and in what time frames they were resolved (see **Section 2.8**). The Contractor must cooperate with EOHHS to implement improvements based on the findings of these reports.
2. The Contractor must report the number, types, and resolutions of Appeals filed, including, for external Appeals, whether the external review was by the CMS Independent Review Entity or by the MassHealth Board of Hearings.

E. Functional Data

The Contractor must report the need for assistance with Activities of Daily Living (ADLs) annually for all Enrollees by age and gender. This data will be collected in accordance with the Comprehensive Assessment and will include the number of Enrollees per 1,000 needing limited assistance and number of Enrollees per 1,000 needing extensive or total assistance with:

1. Mobility;
2. Transfer;
3. Dressing;
4. Eating;
5. Toilet use;
6. Personal hygiene; and
7. Bathing.

F. Mortality Data

The Contractor must report mortality data annually, by age and gender, in the following categories:

1. The number of Enrollees who died during the past year;
2. Percentage who died in hospitals;
3. Percentage who died in nursing facilities;
4. Percentage who died in non-institutional settings; and
5. Cause of death.

G. Medications

The Contractor must report Enrollee-specific prescription data through MDS 2.0 for nursing residents and the MDS-HC for home care.

H. Provider Preventable Conditions

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.

I. Continuity of Operations Plan

In accordance with **Section 5.3**, the Contractor shall annually submit a copy of its Continuity of Operations Plan at the time of submitting annual reports under **Section 2.12.B.12.e**.

J. Compliance Plan

In accordance with **Section 5.2.A**, the Contractor shall annually submit a copy of its Compliance Plan at the time of submitting annual reports under **Section 2.12.B.12.e**.

K. Payment Discrepancy Report

The Contractor must report monthly, in a format specified by EOHHS, a list of payment discrepancies.

L. Contract Compliance Attestation

The Contractor must submit on March 31 of each year a Contract Compliance Attestation reporting on measures determined by EOHHS.

M. Frail Elder Waiver Reporting

The Contractor shall comply with the quality improvement performance measures as described in the Frail Elder Waiver. The Contractor shall submit all materials requested by EOHHS to document the Contractor's compliance with these quality improvement performance measures, in accordance with the form and schedule prescribed by EOHHS.

N. Passive Enrollment Report

The Contractor must submit to EOHHS a monthly report on the outcomes of the Contractor's onboarding activities with regard to members who joined SCO through Passive Enrollment. This report shall be in a form prescribed by EOHHS and shall contain all the data elements required by EOHHS.

O. Community Support Program (CSP) Report

The Contractor must submit to EOHHS a quarterly report on the outcomes of the Contractor's activities with regard to the Community Support Program (CSP). This report shall be in a form prescribed by EOHHS and shall contain all the data elements required by EOHHS.

P. Provider Network Data

The Contractor must submit to EOHHS, on a semi-annual basis, complete provider network data in the format prescribed by EOHHS.

Q. Medical Loss Ratio (MLR) Requirements

1. Medicaid-Only MLR
    a. Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio for those Covered Services for which Medicaid is the payor (Medicaid-only MLR) in accordance with 42 CFR 438.8. The Contractor shall perform such Medicaid-only MLR calculation in the aggregate for the Contractor's Enrollee population and individually for each Rating Category. By July 31 of each year, the Contractor shall report such Medicaid-only MLR calculations for the prior calendar year to EOHHS in a form and format specified by EOHHS and as set forth in **Appendix D**. Pursuant to 42 CFR 438.604(a)(3), such report shall include all of the data on the basis of which EOHHS will determine the Contractor's compliance with the MLR requirement set forth in 42 CFR 438.8, including, but not limited to, the following:
        1) Total incurred claims
        2) Expenditures on quality improving activities;
        3) Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5),(7),(8), and (b);
        4) Non-claims costs;
        5) Premium revenue;
        6) Taxes, licensing, and regulatory fees;
        7) Methodology(ies) for allocation of expenses;
        8) Any credibility adjustment applied;
        9) The calculated MLR, which shall be the ratio of the numerator (as set forth in **Section 2.13.Q.1.b.1**) to the denominator (as set forth in **Section 2.13.Q.1.b.2**);
        10) Any remittance owed to EOHHS, if applicable;
        11) A comparison of the information reported in this Section with the audited financial report required under this **Section 2.11.C**;

12) A description of the aggregation method used in calculating MLR;

13) The number of member months;

14) An attestation that the calculation of the MLR is accurate and in accordance with 42 CFR 438.8; and

15) Any other information required by EOHHS.

b. The Contractor shall calculate its Medicaid-only MLR in accordance with 42 CFR 438.8, as follows:

1) The numerator of the Contractor's Medicaid-only MLR for each year is the sum of the Contractor's incurred Medicaid claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

2) The denominator of the Contractor's Medicaid-only MLR for each year is the difference between the total Medicaid capitation payment received by the Contractor and the Contractor's federal, state, and local taxes and licensing and regulatory fees, all of which must be calculated in accordance with 42 CFR 438.8.

c. The Contractor shall maintain a minimum Medicaid-only MLR of 85 percent in the aggregate for the Contractor's Enrollee population. If the Contractor does not maintain such minimum, the Contractor shall be subject to a corrective action plan or sanctions of a value less than or equal to the difference between the Contractor's actual Medicaid-only MLR numerator and the Medicaid-only MLR numerator that would have resulted in an 85% Medicaid-only MLR for the Contractor. Calculation of the Contractor's Medicaid-only MLR for the purposes of determining whether the Contractor has maintained such minimum shall occur after any reconciliation under the risk-sharing arrangement set forth in **Section 4.7.C.4**.

2. Blended MLR

a. In addition to the Medicaid-only MLR described above, as directed by EOHHS, the Contractor shall calculate and report a Medical Loss Ratio for all Covered Services (regardless of whether Medicare or Medicaid is the payor) in accordance with 42 CFR 438.8 and **Section 2.13.Q.1.a-b** of this Contract (blended MLR).

b. The Contractor shall calculate its blended MLR in accordance with 42 CFR 438.8, as follows:

1) The numerator of the Contractor's blended MLR for each year is the sum of the Contractor's incurred claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

2) The denominator of the Contractor's blended MLR for each year is the difference between the total capitation payment received by the Contractor and the

Contractor's federal, state, and local taxes and licensing and regulatory fees, all of which must be calculated in accordance with 42 CFR 438.8.

3. At its discretion, EOHHS may use the Contractor's submitted encounter data to verify the Contractor's reported Medicaid-only MLR and blended MLR and may impose intermediate sanctions as described in **Section 5.5.Q** in circumstance in which encounter data does not support the Contractor's reported Medicaid-only MLR and/or blended MLR.

R. Annual Performance Report

The Contractor must submit to EOHHS, on an annual basis, a report on the plan's overall performance and the Contractor's insights into both the operation of their plan and the SCO program at large. The report shall include, at a minimum, a description of any innovations being used by the Contractor in connection with its operation of its plan, and any internal or external changes that are impacting the Contractor's approach to the SCO program. Contractor shall report on any efforts to increase Value Based Purchasing arrangements, efforts to improve provider coordination, and efforts to enhance person-centered care.

S. Pharmacy Drug Rebate Data

The Contractor shall collect, manage, and report Drug Rebate Data as described in this Section and as further specified by EOHHS. The Contractor shall:

1. Collect and retain 100% of the Drug Rebate Data in accordance with **Appendix Q**. In addition, the Contractor shall:
   a. Ensure Drug 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 claims to EOHHS and its designee. The Contractor shall satisfy any EOHHS-required timely updates to the file record layouts/schema in response to changing requirements;
   c. As directed by EOHHS, include as part of its Drug Rebate Data information related to denied claims and 340B Drug Rebate indicators;
   d. In the event EOHHS or its designee is unable to accept certain Drug Rebate Data records due to validation errors, retrieve and promptly correct those claim records and resubmit them in accordance with current EOHHS schema and schedules;
   e. Participate in workgroups, discussions, and meetings with EOHHS and its designees to support MassHealth rebate invoicing to drug manufacturers;
   f. Validate that all National Drug Codes (NDCs) submitted on physician-administered drugs for rebate match the Healthcare Common Procedure System (HCPCS) being billed for, and include accurate NDC information (unit of measure and quantity);
   g. Instruct Providers to use the following indicators to identify 340B claims:
      1) For Physician-Administered Drugs add the identifier of "UD" to the HCPCS; and
      2) For Pharmacy-dispensed drugs attach Submission Clarification Code 20; and

h. 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.

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 Rebate Data;
3. Produce Drug Rebate Data according to the specifications, format, and mode of transfer reasonably developed by EOHHS or its designee;
4. Provide Drug Rebate Data to EOHHS monthly or within time frames specified by EOHHS, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations, and guidance;
5. Submit Drug Rebate Data that is 100% on time and 99% complete. To meet the completeness standard, all critical fields in the data must contain valid values. The Contractor shall correct and resubmit errored claims as necessary;
6. Report as voided or reversed any claims in the Drug Rebate Data submission that the Contractor includes in a file and then later determines should not have been included;
7. Ensure that the Drug Rebate contractual requirements are transferred completely and without interruption to the published MassHealth Drug Rebate file upload schedule whenever there is a change in the Drug Rebate operations or technical support staff;
8. If EOHHS or the Contractor determines at any time that the Contractor's Drug Rebate Data will not be or is not 100% on time and 99% complete:
   a. Notify EOHHS, five days prior to the Drug Rebate Data scheduled submission date, that the Drug Rebate Data will not be delivered on time or is not complete and provide an action plan and timeline for resolution;
   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 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 Data is 100% on time and 99% complete. The Contractor may be financially liable for such validation study.

9. 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 having a separate BIN, PCN, and group number combination for MassHealth claims to differentiate them from other claims. The Contractor shall notify EOHHS of BIN, PCN, and group number combination changes as set forth in **Appendix Q**.

Section 2.14 Information Management and Information Systems

A. General

The Contractor shall:

Maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract, as described in this Section and as further directed by EOHHS;

1. Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS;
2. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information, as specified by EOHHS. If directed by EOHHS, the Contractor shall establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal;
3. Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS;
4. 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; and

B. 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-Covered Services);
    b. Claims;
    c. Inquiries, Grievances, Internal Appeals, and BOH Appeals;
    d. Disenrollments for reasons other than for loss of MassHealth eligibility;

e. Provider information in order to comply with **Section 2.5.E**;

f. Services furnished to Enrollees through an Encounter Data system, as specified in **Section 2.13.B** and **Appendix I**;

g. 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 wheelchair dependence, and characteristics gathered through such Plan contact with Enrollees, e.g., Care Needs Screenings administered upon enrollment, Care Management, or other reliable means;

h. 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. As set forth in 42 CFR 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act.

C. Design Requirements

1. 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.

2. The Contractor's Systems shall interface with EOHHS's legacy Medicaid Management Information System (MMIS) and NewMMIS, the EOHHS Virtual Gateway, and other EOHHS IT architecture.

3. 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 shall include, but are not limited to:

   a. Inbound Interfaces

      1) Daily Inbound Demographic Change File;

      2) HIPAA 834 History Request File;

3) Inbound Co-pay Data File (daily); and

4) Monthly Managed Care Provider Directory.

b. Outbound Interfaces

1) HIPAA 834 Outbound Daily File;

2) HIPAA 834 Outbound Full File;

3) HIPAA 834 History Response;

4) Fee-For-Service Wrap Services;

5) HIPAA 820; and

6) TPL Carrier Codes File.

c. SCO Provider Directory Database

1) Provider types and specialties;

2) Working hours;

3) Languages spoken; and

4) Access for disabled Consumers.

4. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.
5. The Contractor shall demonstrate controls to maintain information integrity.
6. The Contractor shall access the state's Virtual Gateway to enroll and disenroll members through Direct Data Entry (DDE) or through the HIPAA 834 transaction.
7. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS.

D. System Access Management and Information Accessibility Requirements

1. The Contractor shall make all Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and Systems.
2. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

E. System Security and Privacy Requirements

The Contractor shall implement administrative, physical and technical safeguards necessary to ensure the confidentiality, availability and integrity of all personally-identifiable data (which shall include, but not be limited to, "protected health information" as such term is defined under HIPAA), as well as any additional security measures required by other state or federal laws or regulations, at EOHHS's request.

Section 2.15 Responsibilities Related to PCAs Employed by the Contractor's Enrollees

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

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

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.

Section 2.16 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. Rate increases described in this **Section 2.16** shall be separate and distinct from rate increases described in **Sections 2.17** and **2.18**.

B. The Contractor shall institute the rate increases and payments as set forth in this section and as further described in MassHealth's managed care entity bulletins, as may be updated from time to time.

1. As further specified by EOHHS, the Contractor shall increase its contracted rates relative to such rates paid as of March 31, 2020, for the following services covered under the traditional Medicaid benefit: Personal Care Attendant Services and other Personal Assistance Services paid at the collectively bargained PCA rate, Home Health Services, Continuous Skilled Nursing, Acute Treatment Services, and Clinical Stabilization Services. Rate increases required under this section must be effective for dates of service on or after April 1, 2020, until further specified by EOHHS. Such rate increases shall apply to services delivered in-person and via telehealth, as applicable.
2. Between July 2, 2020 and July 31, 2020, until further specified by EOHHS the Contractor shall continue to pay its contracted Adult Day Health providers, including if applicable those Adult Day Health providers contracted through an Aging Services Access Point (ASAP), its contracted rates for Adult Day Health services under the traditional Medicaid benefit, for each day an Enrollee was scheduled to attend the Adult Day Health program, provided however that such payments shall only be made for Enrollees for whom the Adult Day Health provider documents at least four qualifying encounters with the Enrollee per month averaging one qualifying encounter per week, as specified by EOHHS. The Contractor shall require its contracted Adult Day Health providers to report to the Contractor, or to the Contractor's contracted ASAP where applicable, on each such encounter in a form and format and at a frequency specified by EOHHS.
3. Adult Day Health Directed Payments
    a. As further specified by EOHHS and in a manner that does not overlap with payments made under **Section 2.16.B.2**, the Contractor shall increase its contracted rates for Adult Day Health services, relative to such rates paid as of February 29, 2020, as described below. Such rate increases shall apply to services delivered via in-person and remote modalities, as applicable.
        1) A 40% increase for dates of service August 1, 2020, through September 30, 2020.

2) A 25% increase for dates of service October 1, 2020, through November 30, 2020. The 25% increase shall supplant the previous 40% increase under **Section 2.16.B.3.a.1** such that the increases are not additive.

3) A 40% increase for dates of service December 1, 2020, through February 28, 2021. This 40% increase shall supplant the previous increases under **Sections 2.16.B.3.a.1** and **2.16.B.3.a.2**.

4) A 25% increase for dates of service March 1, 2021, through December 31, 2021. This 25% increase shall supplant the previous increases under **Sections 2.16.B.3.a.1**, **2.16.B.3.a.2**, and **2.16.B.3.a.3**.

5) A 15% increase for dates of service January 1, 2022, through June 30, 2022. The 15% increase shall supplant the previous increases under **Sections 2.16.B.3.a.1**, **2.16.B.3.a.2**, **2.16.B.3.a.3**, and **2.16.B.3.a.4**.

4. As further specified by EOHHS, for dates of service on or after January 1, 2021, until further specified by EOHHS, for Medicaid-only Enrollees, the Contractor shall conform their rates of payment with MassHealth rates for COVID-19 vaccine administration, monoclonal antibody product infusion, COVID-19 laboratory analysis codes, and high throughput COVID-19 testing.

C. Additional Requirements

1. If the Contractor has sub-capitated or Alternative Payment Methodology (APM) arrangements with providers, 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.
2. 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 made for the services listed in **Section 2.16.B.1**.
3. All encounter file claim paid amounts with dates of service as of the rate increase effective date must reflect the specified rate increases.
4. The Contractor shall certify on a monthly basis in a form and format specified by EOHHS, to compliance with these rate increase requirements. 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.

Section 2.17 Enough Pay to Stay (EPTS) Rate Provisions

A. Rate increases described in this **Section 2.17** shall be separate and distinct from and additive to rate increases described in **Sections 2.16** and **2.18** as set forth in 101 CMR 449.000.

B. As further specified by EOHHS, the Contractor shall increase its contracted rates for the following services as follows:

1. Relative to such rates paid as of December 31, 2020, for dates of service from January 1, 2021, through June 30, 2021:
    a. Homemaker: $0.65 increase per 15-minute unit
    b. Personal Care Services, excluding self-directed Personal Care Attendant Services: $0.65 increase per 15-minute unit
    c. Home Health Aide: $0.67 increase per 15-minute unit
2. Relative to such rates paid as of October 1, 2021, for dates of services from October 1, 2021, through June 30, 2023:
    a. Homemaker: $0.99 increase per 15-minute unit
    b. Personal Care Services, excluding self-directed Personal Care Attendant Services: $0.99 increase per 15-minute unit
    c. Home Health Aide: $0.89 increase per 15-minute unit.

Section 2.18 Directed Payments Related to Certain HCBS Services and Certain Behavioral Health Services

A. Rate increases described in this **Section 2.18** shall be separate and distinct from rate increases described in **Sections 2.16** and **2.17**.

B. As further specified by EOHHS, the Contractor shall increase its contracted rates relative to such rates paid as of June 30, 2021 (except as otherwise specified), for the following home and community-based services covered under the traditional Medicaid benefit and as follows:

1. For Adult Day Health a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2022.
2. For Adult Foster Care a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2023.
3. For Ambulance and Wheelchair Van Services a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2022.
4. For Continuous Skilled Nursing Services:
    a. A 30% rate increase effective for dates of service July 1, 2021, through December 31, 2021;
    b. A 10% rate increase relative to the rates in effect as of January 1, 2022, for dates of service January 1, 2022, through June 30, 2023.
5. For Day Habilitation a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2022.
6. For Durable Medical Equipment a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2022.
7. For Home Health a 10% rate increase effective for dates of service July 1, 2021, through December 31, 2023.
8. For Group Adult Foster Care a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2022.
9. For Personal Care Management services a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2023.
10. For Personal Care Attendant (PCA) Services and other Personal Assistance Services paid at the collectively bargained PCA rate, a 10% rate increase effective for dates of service July 1, 2021, through June 30, 2022.

C. As further specified by EOHHS, the Contractor shall increase its contracted rates relative to such rates paid as of June 30, 2021 (except as otherwise specified), for the following Behavioral Health services covered by MassHealth and as follows:

1. For Emergency Services Program (ESP) and Crisis Stabilization (also referred to as Community Crisis Stabilization) a 10% rate increase effective for dates of service July 1,

2021, through January 2, 2023.

2. For Outpatient Services, including both Mental Health and SUD Clinic Services listed below, a 10% rate increase effective for dates of service July 1, 2021, through December 31, 2023.
    a. Family Consultation
    b. Case Consultation
    c. Diagnostic Evaluation
    d. Dialectical Behavioral Therapy (DBT)
    e. Medication Visit
    f. Couples/Family Treatment
    g. Group Treatment
    h. Individual Treatment
    i. Inpatient-Outpatient Bridge Visit
    j. Acupuncture Treatment
    k. Opioid Replacement Therapy (also referred to as Opioid Treatment Service)
    l. Ambulatory Detoxification (Level II.d) (also referred to as Ambulatory Withdrawal Management)
    m. Psychological Testing
    n. Electro-Convulsive Therapy
    o. Psychological Neuropsychological Testing
3. For Community Support (also referred to as Community Support Program or CSP), including CSP Services for Chronically Homeless Individuals, a 10% rate increase effective for dates of service July 1, 2021, through March 31, 2023.
4. For Psychiatric Day Treatment, Structured Outpatient Addiction Program (SOAP) and Intensive Outpatient Program (IOP) a 10% rate increase relative to the rates in effect as of July 1, 2021, effective for dates of service July 1, 2021, through December 31, 2023.
5. For Partial Hospitalization (PHP) a 10% rate increase effective for dates of service July 1, 2021, through December 31, 2023.
6. For Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services (CSS) for Substance Use Disorders (including Individualized Treatment Services) a 10% rate increase relative to the rates in effect as of July 1, 2021, effective for dates of service July 1, 2021, through December 31, 2023.
7. For Recovery Support Navigators (RSN) a 10% rate increase effective for dates of service July 1, 2021, through December 31, 2023.
8. For Recovery Coaching a 10% rate increase effective for dates of service July 1, 2021, through December 31, 2023.

D. For the following home and community based services covered under the traditional Medicaid benefit and as follows, the Contractor shall establish provider rates at or above 100% of the MassHealth-equivalent rates as specified by EOHHS, unless otherwise directed by EOHHS:

1. For Adult Day Health Services, effective for dates of service on or after July 1, 2023
2. For Day Habilitation Services, effective for dates of service on or after July 1, 2023
3. For Adult Foster Care Services, effective for dates of service on or after July 1, 2023
4. For Personal Care Management Services, effective for dates of service on or after July 1, 2023
5. For Continuous Skilled Nursing Services, effective for dates of service on or after July 1, 2023.

E. For the following Behavioral Health services, the Contractor shall establish provider rates at or above 100% of the MassHealth-equivalent rates as specified by EOHHS, unless otherwise directed by EOHHS:

1. For Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services (CSS) for Substance Use Disorders (including Individualized Treatment Services), effective for dates of service on or after January 1, 2024
2. For Residential Rehabilitation Services, effective for dates of service on or after January 1, 2024
3. For Program of Assertive Community Treatment (PACT) services, effective for dates of service on or after January 1, 2024
4. For Adult Community Crisis Stabilization, effective for dates of service on or after January 1, 2023
5. For Adult Mobile Crisis Intervention, effective for dates of service on or after January 1, 2023
6. For services provided by Community Behavioral Health Centers (CBHCs), which are paid as part of the encounter bundle, effective for dates of service on or after July 1, 2023

F. For hospital ED-based crisis evaluation services, the Contractor shall establish provider rates at or above 100% of the MassHealth-equivalent rates under the MassHealth Acute Hospital Request for Application, effective for dates of service on or after January 3, 2023, unless otherwise directed by EOHHS.

G. For Medicaid Covered Nursing Facility Services, the Contractor shall establish provider rates at or above 100% of the MassHealth-equivalent rates including all applicable add-ons

as specified by EOHHS, effective for dates of service on or after January 1, 2023, unless otherwise directed by EOHHS.

H. For Community Support (also referred to as Community Support Program or CSP), including CSP Services for Homeless Individuals, CSP Services – Tenancy Preservation, and CSP Services for Justice Involved Individuals, the Contractor shall establish rates at or above 100% of the MassHealth-equivalent rates as specified by EOHHS, effective for dates of service on or after April 1, 2023, unless otherwise directed by EOHHS.

SECTION 3. EOHHS RESPONSIBILITIES IN COORDINATION WITH CMS

Section 3.1 Contract Management

A. Administration

EOHHS will coordinate contract management with CMS and will:

1. Designate a Contract Management Team that will include, at least one contract officer from EOHHS and one representative from CMS, authorized and empowered to represent CMS and EOHHS about all aspects of the Contract. The CMS representative and the EOHHS representative will act as liaisons between the Contractor and CMS and EOHHS for the duration of the Contract. The Contract Management Team will:
    a. Monitor compliance with the terms of the Contract. EOHHS will be responsible for the day-to-day monitoring of the Contractor's performance and will periodically report to CMS and the Executive Office of Elder Affairs. CMS will communicate directly with the Contractor as necessary;
    b. Receive and respond to all inquiries and requests made by the Contractor under this Contract in a timely manner;
    c. Meet with the Contractor's Director on a periodic or as-needed basis, resolving issues that arise;
    d. Coordinate requests for assistance from the Contractor and assign staff with appropriate expertise to provide technical assistance to the Contractor;
    e. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor; and
    f. Inform the Contractor of any discretionary action by EOHHS or CMS under the provisions of the Contract;
2. Review, approve, and monitor the Contractor's Outreach and orientation materials and procedures;
3. Review, approve, and monitor the Contractor's Grievance and Appeals procedures;
4. Apply one or more of the sanctions provided in **Section 5.5.Q**, including termination of the Contract in accordance with **Section 5.7**, if CMS and EOHHS determine that the Contractor is in violation of any of the terms of the Contract stated herein;
5. Conduct site visits of the Contractor annually, or as determined necessary to verify the accuracy of reported data;
6. Coordinate the Contractor's external quality reviews conducted by the external quality review organization;
7. 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;

8. If it determines that the Contractor is out of compliance with **Section 5.1.E**. of the Contract, notify the Secretary of such non-compliance and determine the impact on the term of the Contract in accordance with **Section 5.7** of the Contract; and
9. 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 2.5.B.1.f**.

B. Performance Evaluation

EOHHS, in coordination with CMS will, at their discretion:

1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in **Sections 2.12** and **2.13**, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. EOHHS will coordinate with CMS to provide the Contractor with the written results of these evaluations;
2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;
3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and
4. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

Section 3.2 Enrollment, Disenrollment, and Rating Category Determinations

EOHHS and CMS will maintain separate systems to provide:

A. Enrollment, disenrollment, and rating-category determinations;

B. Enrollment, disenrollment, rating-category determination information to the Contractor; and

C. Continuous verification of eligibility status.

Section 3.3 Outreach

EOHHS will coordinate with CMS to:

A. Monitor the Contractor's Outreach activities and distribution of related materials;

B. Coordinate Outreach monitoring activities, as described in **Section 2.10**;

C. Conduct an ongoing review of Outreach activities, including:

1. Approval of all Outreach materials, in all forms, prior to use;
2. Random onsite review of Outreach forums, products, and activities;
3. Random review of actual Outreach pieces as they are used in or by the media; and
4. For-cause review of materials and activities when complaints are made by any source; and

D. If EOHHS or CMS find that the Contractor is violating these requirements, monitor the development and implementation of a corrective action plan.

SECTION 4. PAYMENT AND FINANCIAL PROVISIONS

Section 4.1 General Financial Provisions

A. Capitation Payments

EOHHS will make monthly capitation payments to the Contractor in accordance with the rates of payment and payment provisions set forth herein and in **Appendix N** for all Covered Services actually and properly delivered to eligible Enrollees in accordance with and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive two monthly capitation payments for each Dual Eligible Enrollee: one amount from Medicare and a second amount from MassHealth. Medicare and MassHealth each produce different Rate Cells (RCs). For those Enrollees who are eligible for MassHealth only, the Contractor will receive one monthly capitation payment from MassHealth.

B. Modifications to Capitation Rates

EOHHS will notify the Contractor in advance and in writing of any proposed changes to the Base Capitation Rates by RC. Changes to EOHHS Base Capitation Rates will be established by amendment to this Contract.

C. Risk Adjusted Capitation Rates

EOHHS intends to risk adjust the LTSS and non-medical expense components of the base Capitation Rates for members in the Nursing Home Certifiable (NHC) Rating Category beginning on July 1, 2019, to reflect the different functional and health status (acuity) of NHC Enrollees enrolled in the Contractor's Plan. EOHHS shall use a statistical methodology to calculate functional status-based risk-adjusters using a generally accepted functional status assessment grouper. Such risk adjustment shall be on an aggregation of the individual risk scores of NHC Enrollees enrolled in the Contractor's Plan. EOHHS intends to risk adjust the LTSS and non-medical expense components of the base Capitation Rates at least bi-annually. The risk adjusted Capitation Rate shall equal the sum of the risk adjusted LTSS and non-medical expense components and the administrative component of the base Capitation Rate. The Contractor shall accept as payment in full such risk adjusted Capitation Rates.

D. Health Insurer Provider Fee Adjustment

Each year, to account for the portion of the Contractor's Health Insurer Provider Fee under Section 9010 of the ACA (the HIPF) that is allocable to capitation payments made by EOHHS to the Contractor under this Contract, 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 E**, **Exhibit 1** to the Contractor's Base Capitation Rates to account for the portion of

the Contractor's HIPF that is allocable to capitation payments made by EOHHS to the Contractor under this Contract and, subject to federal financial participation, for the tax liability related to the HIPF, if applicable.

3. For Calendar Year 2014, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after April 22, 2016.
4. For Calendar Year 2015, such adjustment shall be a retroactive, one-time adjustment made as a single payment on or after April 22, 2017.
5. For Calendar Year 2017, such adjustment shall be a retroactive, one-time adjustment made as a single payment on or after January 1, 2019.
6. For Calendar Year 2019, such adjustment shall be a retroactive, one-time adjustment made as a single payment on or after December 1, 2021.

E. COVID-19 Vaccination Incentive Payment

1. For Calendar Year 2021, EOHHS shall provide the Contractor with a vaccine incentive payment if, by June 30, 2021, the Contractor ensures that at least eighty-five (85%) percent of the Plan's eligible Enrollees as specified below are fully vaccinated (i.e. all doses of the recommended regimen for the applicable vaccine are administered) or it is one of the top two SCO plans with a vaccination rate above fifty (50%) percent. Enrollees in the Contractor's plan eligible to be counted towards the percent vaccination threshold shall:
   a. Reside in the cities and towns identified by DPH as most disproportionately impacted by COVID-19, as further directed by EOHHS; and
   b. Exclude those Enrollees in Institutional Rating Categories, as set forth in **Appendix N**, as of January 1, 2021.
      1) Subject to the Contractor meeting the requirements set forth in **Section 4.1.E** above, such vaccine incentive payment shall be $500,000.
      2) Such vaccine incentive payment shall be excluded from the calculation of Medical Loss Ratios as described in **Section 2.13.Q** and the Contract-Wide Risk Sharing Arrangement as described in **Section 4.7.C.4** and **Appendix E**.
2. Such incentive arrangement is available to both public and private Contractors under the same terms of performance. Participation in this incentive arrangement is not conditioned upon the Contractor entering into or adhering to intergovernmental transfer agreements. Such incentive arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the state's quality strategy.

Section 4.2 Medicare Payment

To obtain payment from Medicare, the Contractor shall comply with the Medicare-Advantage-Part D provisions.

Section 4.3 Payment Terms

EOHHS will make monthly capitation payments to the Contractor. The MassHealth capitation payment for each RC will be the product of the number of Enrollees in each category multiplied by the payment rate for that RC. Patient contribution to care amounts will be deducted from the total MassHealth monthly capitation payment amount, in accordance with **Section 4.3.B**.

A. Timing of Capitation Payments

1. New Enrollments

EOHHS will make capitation payments for Enrollees. Enrollments received and approved by EOHHS on or before the last business day of the month will be effective the first calendar day of the following month. EOHHS will make monthly capitation payments to the Contractor for the month beginning on the effective date of enrollment.

2. Disenrollments

If an Enrollee (or Enrollee's representative) signs a disenrollment form and submits it to EOHHS on or before the last business day of the month, the Enrollee's disenrollment will be effective on the first calendar day of the following month, provided that the Enrollee's request to disenroll accords with federal and state laws and regulations (including 130 CMR 508.008(D) and this Contract (including **Section 2.3.G.1**). The final capitation payment made by EOHHS to the Contractor for this Enrollee will be for the month in which the disenrollment was submitted.

3. After an Enrollee's Death

If an Enrollee dies, he or she will be disenrolled as of the date of his or her death. EOHHS's final capitation payment for an Enrollee who dies will be for the month in which the Enrollee died. The Contractor is not entitled to capitation payments for subsequent months. In addition, EOHHS will calculate a revised, pro-rated monthly capitation payment for the month in which the Enrollee died, to reflect the number of days that month in which the Enrollee was enrolled with the Contractor. As part of the reconciliation process described in **Section 4.4**, EOHHS will recoup the difference between this pro-rated monthly capitation payment and the capitation payment received by the Contractor on account of that Enrollee.

B. Patient Contribution to Care Amounts

If, in the financial eligibility process conducted by EOHHS, an Enrollee residing in a nursing facility is determined to owe a monthly patient-paid amount, such amounts are the Enrollee's contribution to care. At the time of enrollment, and as adjusted thereafter,

EOHHS will advise the Contractor of the amount of the Enrollee's contribution to care. When an Enrollee contribution to care is established, EOHHS will subtract that amount from the monthly capitation payment for that Enrollee. The Contractor is responsible for collecting this amount from the Enrollee subject to the Enrollee rights provisions of the Contractor's Evidence of Coverage (see **Appendix B**).

C. American Recovery and Reinvestment Act of 2009

All payments to the Contractor are conditioned on compliance with the provisions below, 42 CFR 438.14, and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. The Contractor shall:

1. Offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain Covered Services from out-of-network Indian Health Care Providers from whom the Enrollee is otherwise eligible to receive such services. The Contractor shall also permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider;
2. Demonstrate that there are sufficient Indian Health Care Providers participating in its Provider Network to ensure timely access to services available under this Contract from such providers for Indian Enrollees who are eligible to receive such services;
3. Pay both network and non-network Indian Health Care Providers who provide SCO 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 SCO Covered Service provided by a non-Indian Health Care Provider or the MassHealth fee for service rate for the same service, whichever is greater;
4. Make prompt payment to Indian Health Care Providers in accordance with **Section 5.1.I** of this Contract;
5. Pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 CFR 438.14(c)(1); and
6. Not impose enrollment fees, premiums, cost sharing, or similar charges on Indian Enrollees who are eligible to be served or have ever been served by an Indian Health Care Provider or through referral under contract health services

Section 4.4 Reconciliation

EOHHS will implement a process to reconcile enrollment and capitation payments for each Contractor that will take into consideration the following circumstances: transitions

between RCs; retroactive changes in eligibility, RCs, or patient contribution amounts; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

A. MassHealth Capitation Reconciliation

EOHHS will:

1. Perform a quarterly reconciliation of the monthly capitation payments as described below:
   a. Calculate the correct Capitation Rate for each month per Enrollee by determining the Enrollee's appropriate RC and the appropriate patient contribution; and
   b. Reconcile the monthly Capitation Rate paid per Enrollee for each month of the quarter with the correct Capitation Rate as calculated in **Section 4.4.A.1.a** above; and
2. Remit to the Contractor the full amount of any underpayment it identifies pursuant to **Section 4.4.A.1.a**. The Contractor must remit to EOHHS the full amount of any overpayments identified by EOHHS pursuant to **Section 4.4.A.1**. Such payment shall be made through a check or other funds transfer method acceptable to EOHHS, or, at the discretion of EOHHS, through adjustment or recoupment of future capitation and/or reconciliation payments.
3. EOHHS at its discretion may choose to perform other periodic reconciliations of the monthly capitation payments.

B. Audits

EOHHS will conduct periodic audits to validate RC assignments. Audits may be conducted by a peer review organization or other entity assigned this responsibility by EOHHS.

Section 4.5 Federal Payment Approval

The federal government requires that states meet certain state plan requirements and certify to the federal government that MassHealth capitation payments do not exceed the cost of providing Covered Services on a fee-for-service basis to an actuarially equivalent population. If any portion of the MassHealth capitation payment methodology is not approved by CMS, any payment made by EOHHS in excess of the MassHealth payments resulting from the federally approved methodology will be deemed an overpayment. EOHHS may collect such overpayment through a deduction from future payments to the Contractor.

Section 4.6 Payment in Full

The Contractor must accept, as payment in full for all obligations under this Contract, the MassHealth Capitation Rates and the terms and conditions of payment set forth

herein.

Section 4.7 Risk Sharing Arrangement

A. General Requirement

The Contractor shall participate in any risk-sharing arrangement as directed by EOHHS in each Contract Year.

B. General Provisions

1. 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.
2. The Contractor shall submit to EOHHS the following data to assist EOHHS in calculating applicable medical expenditures for the risk sharing arrangement in this Section:
    a. Encounter Data, as specified in this Contract;
    b. Reports submitted by the Contractor applicable to the risk sharing arrangement, including those set forth in **Appendix D**;
    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. For purposes of the Contractor's risk sharing arrangement, actual medical expenditures are defined as the numerator of the Contractor's Medicaid-only MLR for each year, which is the sum of the Contractor's incurred Medicaid claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities as set forth in **Section 2.13.Q.1.b.1** of this Contract, all of which must be calculated in accordance with 42 CFR 438.8.
3. 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.

C. Risk Sharing Arrangement for the Contract Year

For all Rating Categories, the Contractor and EOHHS shall share risk on the difference between the Medical Component of the Capitation Rate Payment and Actual Medical Expenditures in accordance with the following provisions.

1. Overall Approach

    All payments shall be calculated and determined by EOHHS based on the Contractor's actual medical expenditures relating to all Enrollees, defined as the

numerator of the Contractor's Medicaid-only MLR as specified in **Section 2.13.Q.1.b.1** ("Actual Medical Expenditures"), and Medical Component of the Capitation Rate Payment, as set forth below.

2. Medical Component of the Capitation Rate Payment

   a. The medical component of the Capitation Rate Payment is the sum of:

      1) The medical component of the risk adjusted Capitation Rate Payment for the NHC RC for the applicable Contract Year; and

      2) The medical component of the Capitation Rate Payment for all other Rating Categories for the applicable Contract Year.

   b. The Contractor's medical component of the risk adjusted Capitation Rate Payment for the NHC RC for the Contract Year shall mean the sum of the risk adjusted Capitation Rate Payments actually paid by the EOHHS for each month of the Contract Year for the NHC RC, multiplied by the Target MLR percentage for the NHC RC, as determined by the EOHHS pursuant to 42 CFR 438.604(a)(3) and as further specified by EOHHS.

   c. The Contractor's medical component of the Capitation Rate Payment for all other Rating Categories shall be the sum of the Capitation Rate payments actually paid by EOHHS for each month of the Contract Year for each Rating Category, multiplied by the Target MLR percentage for each Rating Category, as determined by the EOHHS pursuant to 42 CFR 438.604(a)(3) and as further specified by EOHHS.

3. Actual Medical Expenditures

   EOHHS shall then determine the Contractor's Actual Medical Expenditures in aggregate across all Rating Categories related to the provision of SCO Covered Services in **Appendix A** for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.7.B.** above, and may verify such data in a manner it determines appropriate.

   a. Expenditures shall include only the expenditures defined in the numerator of the MLR calculation pursuant to **Section 2.13.Q.1.b.1** of this Contract.

   b. For the reports specified in **Section 4.7.B.2.b** above, the Contractor shall include 6 months of claims run-out.

4. If the Contractor's Actual Medical Expenditures (based on the numerator of the MLR as defined in **Section 4.7.c.3.a** above, as determined by EOHHS in accordance with the above provisions across all Rating Categories) is greater than or less than the Medical Component of the Capitation Rate payment, EOHHS and the Contractor shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Appendix E**, **Exhibit 2**.

5. 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.

SECTION 5. ADDITIONAL TERMS AND CONDITIONS

Section 5.1 Administration

A. Notification of Administrative Changes

The Contractor must notify EOHHS and CMS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify EOHHS and CMS in writing no later than 30 calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a Subcontractor pursuant to **Section 2.5.C.3.** The Contractor must notify EOHHS and CMS in writing of all other changes no later than five business days prior to the effective date of such change.

B. Assignment

The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity, including Subcontractors, without the prior written consent of EOHHS and CMS, which may be withheld for any reason or for no reason at all.

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 the federal government, the Commonwealth of Massachusetts, EOHHS, or CMS.

D. Subrogation

Subject to EOHHS and CMS lien and third-party recovery rights, the Contractor must:

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;
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. The Contractor may ask the Enrollee to:
    a. 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 take no action prejudicing the rights and interest of the Contractor hereunder; and
    b. Notify the Contractor hereunder and 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. Prohibited Affiliations

In accordance with 42 USC §1396 u-2(d)(1), 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 excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor. The Contractor shall provide written disclosure to EOHHS of any prohibited affiliations identified by the Contractor.

The Contractor warrants and represents that it will not, in accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, 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, under federal or state law, regulation, executive order, or guidelines, from certain procurement and non-procurement activities. The Contractor further warrants and represents that 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. In the event that EOHHS learns that the Contractor has a prohibited affiliation with a person or entity who is debarred, suspended, or excluded from participating in federal healthcare programs, EOHHS (a) must notify the Secretary of the noncompliance, (b) may continue the SCO Contract unless the Secretary directs otherwise, and (c) may not renew or extend the SCO Contract unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b). The Contractor further warrants and represents that the Contractor does not meet any of the conditions set forth in 42 CFR 438.808(b).

F. 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., 42 CFR 1002.3 and 42 USC § 1396b(m)(4)(A) in the form and format specified by EOHHS.

a. Ownership and Control

Upon the Contractor's submission of a proposal in accordance with the State's procurement process, upon the Contractor's execution of this Contract, 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 Subcontractors.

b. Business Transactions

Within 35 days of a written request by EOHHS and/or the U.S. Department of Health and Human Services, the Contractor shall furnish full and complete information to 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. Sanctioned Individuals

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 1002.3, regarding sanctioned individuals as described under 42 CFR 1001.1001(a)(1).

e. Other Disclosures

The Contractor shall comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. Pursuant to 42 U.S.C. § 1396b(m)(4)(B), the Contractor shall make any information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to 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.F.2.a-e**, 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 G**. EOHHS may update or replace **Appendix G** 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.F** or in response to the information contained in the Contractor's disclosures under this **Section 5.1.F**. 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.

G. Physician Identifier

The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. §1320d-2(b). The Contractor must provide such unique identifier to EOHHS and CMS for each of its PCPs in the format and time frame established by EOHHS and CMS in consultation with the Contractor.

H. Denial of Claims Related to Clinician-Administered Drugs

To enable EOHHS to collect available drug rebates, the Contractor shall not pay any claims for clinician-administered drugs in cases where the claims are missing any of the following required data elements:

1. National Drug Code;
2. Metric Quantity; and
3. Unit of Measure.

In any instance in which the Contractor denies payment in accordance with this section, in addition to any prohibitions on balance-billing set forth in this Contract (including **Section 5.1.K.5**), the Contractor shall ensure that the Provider does not attempt to bill the Enrollee for such clinician-administered drugs.

I. Timely Payments to Contracted Providers

The Contractor must make timely payments to Providers for SCO Covered Services furnished to Enrollees in accordance with 42 USC 1396u-2(f) and 42 CFR 447.46. The Contractor must ensure that ninety (90%) percent of payment claims from practitioners who are in individual or group practice, which can be processed without obtaining additional information from the practitioners or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine (99%) percent of all claims from Covered Service providers will be paid within 90 days from the date the Contractor receives the claim. The Contractor and its providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the day the Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment. The Contractor shall submit claims processing reports on timely payment to providers monthly and annually as specified in **Appendix D**.

J. Protection of Enrollee-Provider Communications

1. In accordance with 42 USC §1396 u-2(b)(3), 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 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 terms of the Contract.

K. Protecting Enrollee from Liability for Payment

1. In accordance with 42 USC §1396 u-2(b)(6), the Contractor shall not hold an Enrollee liable for:

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

b. Services (other than Excluded Services) provided to the Enrollee in the event that the Contractor fails to receive payment from EOHHS or CMS for such services; or

c. Payments to a clinical Subcontractor in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services.

2. The Contractor shall not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

3. The Contractor shall not deny any service provided under this Contract to an Enrollee who, prior to becoming MassHealth eligible, incurred a bill that has not been paid;

4. The Contractor shall ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing and co-payment provisions, and develop and implement a plan to identify and sanction any member of the Contractor's Provider Network that does not comply with such provisions;
5. The Contractor shall 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.6** through **Section 5.1.K.8** below;
6. The Contractor shall ensure that any cost-sharing imposed on Enrollees is in accordance with 42 CFR 447.50 through 447.82, and with all applicable MassHealth regulations, including 130 CMR 450, 130 CMR 506, and 130 CMR 520;
7. For pharmacy products:
    a. The Contractor may charge co-payments equal to no more than the lower of:
        1) The applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low-Income Subsidy; or
        2) The applicable MassHealth co-payment amounts.
    b. The Contractor shall institute a cap on out-of-pocket pharmacy co-payment expenses for a calendar year, a calendar quarter, or a month as directed by EOHHS. All pharmacy co-payments paid by the Enrollee under the Contractor's pharmacy benefit shall count toward this cap. The cap and the period of time to which the cap applies may change during the Contract term.
    c. The Contractor may establish lower co-payments for pharmacy products than the maximum allowed under this Section, including $0 co-payments.
8. The Contractor shall conform its cost sharing policies and requirements to adapt to EOHHS specifications, as may be updated from time to time.

L. Payments to Federally Qualified Health Centers and Rural Health Centers

M. 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 114.3 CMR 4.00, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

N. Accreditation

1. The Contractor shall inform the State whether it has been accredited by a private independent accrediting entity, including but not limited to NCQA accreditation.
2. If the Contractor has received accreditation by a private independent accrediting entity, the Contractor must authorize that accrediting entity to provide the State a

copy of its most recent accreditation review, including:

a. Its accreditation status, survey type, and level (if applicable);

b. Recommended actions or improvements, corrective action plans, and summaries of findings; and

c. The expiration date of the accreditation.

Section 5.2 Program Integrity, Fraud and Abuse Prevention, Detection and Reporting

A. Program Integrity Requirements

1. General Provisions

   The Contractor shall:

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

   b. Implement and maintain written internal controls, policies and procedures, and administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, correct and report known or suspected Fraud, waste and Abuse activities consistent with 42 CFR 438.608(a) and as further specified in this Contract.

   c. In accordance with federal law, including but not limited to Section 6032 of the federal Deficit Reduction Act of 2005, make available written Fraud and Abuse policies to all employees. If the Contractor has an employee handbook, the Contractor shall include specific information about such Section 6032, the Contractor's policies, and the rights of employees to be protected as whistleblowers.

   d. Meet with EOHHS regularly and upon request to discuss Fraud, waste and Abuse, audits, overpayment issues, reporting issues, and best practices for program integrity requirements.

   e. At EOHHS' discretion, implement certain program integrity requirements for Providers, as specified by EOHHS, including but not limited to implementing National Correct Coding Initiative edits or other CMS claims processing/provider reimbursement manuals, and mutually agreed upon best practices for program integrity requirements.

2. Compliance Plan

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

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

1) Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state laws regarding Fraud, waste and Abuse;

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

3) Adequate Massachusetts-based staffing and resources to investigate incidents and develop and implement plans to assist the Contractor in preventing and detecting potential Fraud, waste, and Abuse activities. Staff conducting program integrity activities for the Contractor shall be familiar with MassHealth and state and federal regulations on Fraud, waste and Abuse.

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

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

6) Enforcement of standards through well-publicized disciplinary guidelines;

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

8) Provision for prompt response to detected offenses, and for development of corrective action initiatives, as well as the reporting of said offenses and corrective actions to EOHHS as stated in this Contract and as further directed by EOHHS; and

9) Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this Section.

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

3. Anti-Fraud, Waste, and Abuse Plan

a. The Contractor shall have an anti-Fraud, waste, and Abuse plan.

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

1) Require that the reporting of suspected and confirmed Fraud, waste, and Abuse be performed as required by this Contract;

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

    a) 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).

    b) With such submission, the Contractor shall provide details of such action and outline activities for employee education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, 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, waste, and Abuse plan;

3) Outline activities for Provider education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, waste, and Abuse, specifically related to identifying and educating targeted Providers with patterns of incorrect billing practices or overpayments;

4) Contain procedures designed to prevent and detect Fraud, waste, and Abuse in the administration and delivery of services under this Contract; and

5) Include a description of the specific controls in place for prevention and detection of potential or suspected Fraud, waste, and Abuse, such as:

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

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

    c) A description of desk and onsite 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;

6) The Contractor shall have its anti-Fraud, waste, and Abuse plan in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its compliance plan in accordance with **Appendix D**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

4. MassHealth Overpayments

a. Reporting MassHealth Overpayments to EOHHS

1) This **Section 2.3.D.4** shall apply to overpayments for Medicaid-only services. This **Section 2.3.D.4** shall not apply to overpayments for Medicare covered services.

2) The Contractor shall report overpayments to EOHHS using the following reports as specified in this section and **Appendix D**:

a) Notification of Provider Overpayments Report;

b) Fraud and Abuse Notification Report;

c) Summary of Provider Overpayments Report; and

d) Self-Reported Disclosures Report.

3) In accordance with **Appendix D**, the Contractor shall submit to EOHHS the Notification of Provider Overpayments Report and Fraud and Abuse Notification Report no later than five business days after the identification of the overpayment.

4) In accordance with **Appendix D**, the Contractor shall submit to EOHHS the Summary of Provider Overpayments Report as follows:

a) The Contractor shall report all overpayments identified, including but not limited to those resulting from potential Fraud, as further specified by EOHHS.

b) The Contractor shall, as further specified by EOHHS, report all overpayments identified during the Contract Year, regardless of dates of service, and all investigatory and recovery activity related to those overpayments. This report shall reflect all cumulative activity for the entire Contract Year plus six months after the end of the Contract Year.

c) For any overpayments that remain unrecovered for more than six months after the end of the Contract Year, the Contractor shall continue to report all cumulative activity on such overpayments until all collection activity is completed.

b. Identifying and Recovering Overpayments:

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

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

   b) In the event the Contractor does not recover an overpayment first identified by the Contractor within one hundred and eighty (180) days after such identification, the Contractor shall provide justification in the Summary of Provider Overpayments report for any initial overpayment amounts identified but not recovered. EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with **Section 5.4.Q**.

2) If EOHHS identifies an overpayment prior to the Contractor (such that the Contractor did not identify and report to EOHHS the overpayment in accordance with all applicable Contract requirements, including but not limited to the Summary of Provider Overpayments Report, within 180 days of the date(s) of service associated with any claim(s) included in the overpayment):

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

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

   c) If the Contractor agrees with EOHHS's finding:

      (i) The Contractor's response shall provide the amount of each overpayment agreed to.

      (ii) The Contractor shall complete collections of such agreed-upon overpayments. The Contractor shall submit a report to EOHHS of such collections within 90 days of the Contractor's response to EOHHS's notification, in the Agreed Upon Overpayments Collection Report as specified in **Appendix D**.

   d) In the event the Contractor recovers an agreed-upon overpayment first identified by EOHHS within 90 days of the Contractor's response to EOHHS's notification, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to 80% of the agreed-upon overpayment amount in accordance with **Section 5.4.Q**. The Contractor shall retain the remaining 20% of the agreed-upon

overpayment amount collected. In the event EOHHS determines that there is a valid justification for any agreed-upon overpayment amounts that cannot be collected (e.g., MFD hold), this Capitation Payment deduction shall be calculated based on the amount collected instead of the initial agreed-upon overpayment amount.

e) In the event the Contractor does not recover an overpayment first identified by EOHHS within 90 days of the Contractor's response to EOHHS's notification, without providing sufficient justification for any initial overpayment amounts identified but not recovered as determined by EOHHS, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with **Section 5.4.Q**.

f) No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.

g) EOHHS shall calculate, following the end of the Contract Year, any and all Capitation Payment deductions for the prior Contract Year pursuant to this section.

h) In the alternative to the above process, EOHHS may, in its discretion, recover the overpayment and may retain any overpayments collected.

c. Other Requirements Regarding Overpayments

1) The Contractor shall maintain and require its Providers to use a mechanism for the Provider to report when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment. The Contractor shall report any such notifications by its Providers to EOHHS in the Self-Reported Disclosures report.

2) The Contractor may not act to recoup improperly paid funds or withhold funds potentially due to a Provider when the issues, services or claims upon which the recoupment or withhold is based on the following:

a) The improperly paid funds were recovered from the Provider by EOHHS, the federal government or their designees, as part of a criminal prosecution where the plan had no right of participation, or

b) The improperly paid funds currently being investigated by EOHHS are the subject of pending federal or state litigation or investigation, or are being audited by EOHHS, the Office of the State Auditor, CMS, Office of the Inspector General, or any of their agents.

5. Suspected Fraud

a. General Obligations

The Contractor Shall:

1) Report, within five business days, in accordance with **Appendix D** and all other Contract requirements, any allegation of Fraud, waste, or Abuse regarding an Enrollee or subcontractor, or EOHHS contractor, consistent with 42 CFR 455.2 or other applicable law to EOHHS;

2) Notify EOHHS, and receive EOHHS approval to make such contact, prior to initiating contact with a Provider suspected of Fraud about the suspected activity;

3) Take no action on any claims which form the basis of a Fraud referral to EOHHS, including voiding or denying such claims and attempting to collect overpayments on such claims;

4) Provide to EOHHS an annual certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding suspected Fraud including but not limited to the requirement to report any allegation of fraud to EOHHS;

5) Suspend payments to Providers for which EOHHS determines there is a credible allegation of Fraud pursuant to 42 CFR 455.23, **Section 2.5.B**, and or as further directed by EOHHS, unless EOHHS identifies or approves the Contractor's request for a good cause exception as set forth in 42 CFR 455.23(e).

   a) As further directed by EOHHS, after the conclusion of a Fraud investigation that results in a verdict or settlement obtained by the Office of the Attorney General (AGO) Medicaid Fraud Division the Contractor shall disburse to EOHHS any money the Contractor held in a payment suspension account connected to the investigation to account for the verdict or settlement.

   b) As further directed by EOHHS, if the amount of money the Contractor held in the payment suspension account exceeds the Provider's liability under the verdict or settlement, the Contractor shall release to the Provider the amount of money that exceeds the Provider's liability under the verdict or settlement.

   c) As further directed by EOHHS, if EOHHS determines the Contractor may receive a finders' fee performance incentive as described in **Section 5.2.A.5.b.2**, below, the Contractor may retain any money in a payment suspension account necessary to satisfy all or part of the amount of such finders' fee performance incentive. If the Contractor is entitled to a finder's fee performance incentive in an amount greater

than the amount held in a payment suspension account, EOHHS will pay the Contractor the difference between the amount of the performance incentive and the amount in the payment suspension account.

6) The Contractor and, where applicable, its ACO Partner and subcontractors shall cooperate, as reasonably requested in writing, with the Office of the Attorney General's Medicaid Fraud Division, the Office of the State Auditor's Bureau of Special Investigations (BSI), or other applicable enforcement agency. Such cooperation shall include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

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

1) Except as otherwise provided within this section, EOHHS shall retain all monetary recoveries made by MFD arising out of a verdict or settlement with Providers.

2) The Contractor shall receive a finders' fee performance incentive as follows:

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

(i) The Contractor made a Fraud referral to EOHHS pursuant to **Section 5.2.A.5**.

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

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

(iv) The Contractor complies with all other obligations in **Section 5.2.A.5**;

(v) The Contractor made its Fraud referral to EOHHS prior to MFD's investigation becoming public knowledge; and

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

b) If EOHHS determines the Contractor meets the requirements to receive a finders' fee performance incentive, the amount of the incentive payment shall be equal to 50% of the Contractor's pro rata amount of the net state share of the total settlement or verdict amount, based on the Contractor's percentage of the single damages from covered conduct over the relevant time period as determined by EOHHS. The net state share is the gross amount of the verdict or settlement minus any amounts owed as a repayment of federal financial participation to the federal government or other restitution called for in the verdict or settlement.

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

6. Other Program Integrity Requirements

The Contractor shall:

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

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

c. Report promptly to EOHHS, in accordance with **Appendix D** and all other Contract requirements, when it receives information about an Enrollee's circumstances that may affect their MassHealth eligibility, including but not

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

d. Report no later than five business days to EOHHS, in accordance with **Appendix D** and all other Contract requirements, when it receives information about a Provider's circumstances that may affect its ability to participate in the Contractor's network or in MassHealth, including but not limited to the termination of the Provider's contract with the Contractor;

e. Verify, in accordance with other Contract requirements, through sampling, whether ACO Covered Services that were represented to be delivered by Providers were received by Enrollees. The Contractor shall report the identification of any overpayments related to ACO Covered Services that were represented to be delivered by Providers but not received by Enrollees in the following reports as set forth in **Appendix D**: Fraud and Abuse Notification, Notification of Provider Overpayments, and Summary of Provider Overpayments report.

f. Provide employees, as well as Material Subcontractors and agents, detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including whistleblower protections

   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 shall:

      a) On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, in accordance with **Appendix D** 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

   3) Failure to comply with this Section may result in intermediate sanctions in accordance with **Section 5.4.Q**

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

   1) Assess and strengthen internal controls to ensure claims are submitted and payments properly made, including but not limited to:

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

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

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

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

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

h. 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;

i. 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;

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

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

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

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

7. Screening Employees and Contractors

The Contractor shall screen employees and subcontractors by searching the Office of the Inspector General List of Excluded Individuals Entities and exclusion databases, including but not limited to those listed in **Appendix I** to determine if any such individuals or entities are excluded from participation in federal health care programs.

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

b. The Contractor shall notify EOHHS of any discovered exclusion of an employee or subcontractor within two business days of discovery.

c. The Contractor shall require its Providers to also comply with the requirements of this section with respect to its own employees and subcontractors.

8. Screening Providers

The Contractor shall screen Providers in accordance with the requirements set forth in **Section 2.5**.

B. Enrollment Broker Education

The Contractor shall participate in educational sessions, at the request of EOHHS, to update EOHHS staff and its designated Enrollment Broker regarding information which would assist prospective Enrollees in evaluating the Contractor's Plan. These educational activities may include multiple presentations per Contract Year in a form and format and at locations specified by EOHHS.

Section 5.3 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 shall be implemented.

Section 5.4 Privacy and Security of Personal Data and HIPAA Compliance

A. Statutory Requirements

The Contractor shall comply with all applicable requirements regarding the privacy, security, use and disclosure of personal data (including protected health 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. The Contractor understands and agrees that EOHHS may require specific written assurances and further agreements regarding the security and privacy of protected health

information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 CFR, parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under M.G.L. c. 66A. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in course of fulfilling its obligations under this Contract in accordance with applicable State and federal laws.

B. Personal Data

The Contractor must annually inform and provide training to each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance of the laws and regulations relating to the confidentiality of protected health information under HIPAA.

C. Data Security

The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member or Enrollee names.

D. Return of Personal Data

The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of EOHHS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by EOHHS, will destroy such data or material.

Section 5.5 General Terms and Conditions

A. Applicable Law

The term "applicable law," as used in this Contract, means, without limitation, all statutes, orders, rules 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, all applicable law

includes 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 Byrd Anti-Lobbying Amendment; Equal Employment Opportunity requirements, as provided in 41 CFR 60; and Titles XVIII and XIX of the Social Security Act.

B. Massachusetts Law

The laws of the Commonwealth of Massachusetts govern this Contract, including all rights, obligations, matters of construction, validity, and performance.

C. Massachusetts Appropriations Law

All MassHealth Contract payments hereunder are subject to appropriation pursuant to M.G.L. c.29, §26, and will be limited to the amount appropriated therefore to the extent permitted under applicable federal and State laws.

D. Sovereign Immunity

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Massachusetts or EOHHS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

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 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. Loss of Licensure

If, at any time during the term of this Contract, the Contractor or any of its Subcontractors incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to EOHHS and CMS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.7**.

G. Indemnification

The Contractor shall indemnify and hold harmless EOHHS, CMS, the federal government, and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS and CMS, or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any

negligent action, inaction, or willful misconduct of the Contractor, 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 and CMS become aware of the claim; and
2. The Contractor is afforded an opportunity to participate in the defense of such claims.

H. Prohibition against Discrimination

1. In accordance with 42 USC §1396 u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any medical care practitioner who is acting within the scope of the practitioner's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines a request to include individual or groups of practitioners in its network, it must give the affected practitioners 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 USC § 1396u-2, 42 CFR 438.3(d), 42 CFR 438.210(a)(3)(ii), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate against, and will not use any policy or practice that has the effect of discriminating against, a MassHealth Member eligible to enroll in the Senior Care Options Program on the basis of health status, need for health care services, diagnosis, illness, race, color, sex, sexual orientation, gender identity, disability, or national origin.

I. Anti-Boycott Covenant

During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, EOHHS will be entitled to rescind this Contract in the event of noncompliance with this **Section 5.5.I**. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the Contractor.

J. 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 must 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 directed by EOHHS, the Enrollee, regulatory agencies of the Commonwealth, or the United States Government. With respect to Enrollees who are in the custody of the Commonwealth, the Contractor must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.

K. Other Contracts

Nothing contained in this Contract must 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 must provide EOHHS with a complete list of such plans and services, upon request. EOHHS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other Provider, in the same Service Area.

L. Intellectual Property

1. Contractor Property and License

    a. The Contractor will retain all right, title and interest in and to all intellectual property developed by it, (i) for clients other than the Commonwealth, and (ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor in connection with such work product (hereinafter the "Contractor Property"). EOHHS acknowledges that its possession or use of Contractor Property will not transfer to it any title to such intellectual property.

    b. Except as expressly authorized in this Contract, EOHHS will not use, copy, modify, publicly display, publicly perform, distribute, transmit or transfer by any means, display, or sublicense the Contractor Property.

    c. The Contractor grants EOHHS a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit and create derivative works based upon the Contractor Property, in any media now known or hereafter known, but only to the extent reasonably necessary for EOHHS's purposes pursuant to this Contract.

    d. Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS's use of the Contractor Property under the license

created herein, the Contractor shall have all the rights and incidents 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.

2. EOHHS Property

   a. In conformance with the Commonwealth Terms and Conditions, except for the Contractor Property, the Contractor acknowledges and agrees that any and all tasks, deliverables and other work product (which includes, but is not limited to, all reports, summaries, documentation, outlines, plans, processes, know-how, methodologies, layouts, presentations, designs, graphics, specifications, results, user manuals, training materials, work flows, data flows and content) created for or provided to EOHHS by the Contractor or, where applicable, any of its Subcontractors as a result of the Contractor's performance of the services described herein, or other obligation set forth in this Contract (collectively "EOHHS Property") are "works made for hire" as such term is defined in the U.S. Copyright Act, and all right, title and interest in the EOHHS Property shall belong to EOHHS. If any EOHHS Property is not subject to the "works made for hire" provisions of the Copyright Act, the Contractor hereby assigns, on behalf of itself and its Subcontractors, to EOHHS, all right, title and interest the Contractor or its Subcontractors may now have or hereafter acquire in and to all such EOHHS Property and the results of all services provided by the Contractor or its Subcontractors hereunder. The Commonwealth of Massachusetts and its assignees shall be the sole owner of all patents, copyrights, trademarks, trade secrets, and other rights and protection in the EOHHS Property. The Contractor agrees to assist EOHHS to obtain and enforce patents, copyrights, trademarks, trade secrets, and other rights and protection relating to such EOHHS Property, and, to that end, the Contractor shall execute all documents used in applying for and obtaining such patents, copyrights, trademarks, trade secrets and other rights and protection on and enforcing such EOHHS Property as EOHHS may desire, together with any assignments thereof to EOHHS.

   b. To the extent that any Contractor or third-party intellectual property (collectively, the "Third Party Property") is contained in any EOHHS Property, the Contractor hereby grants to EOHHS a fully paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit and create derivative works of the Third Party Property. Nothing in the foregoing provisions restricts EOHHS from licensing the EOHHS Property or Third Party Property to the U.S. Department of Health and Human Services or any other federal or state agency in accordance with applicable regulations. The Contractor hereby represents and warrants that it has obtained all necessary rights and clearances and has the authority to grant the rights and licenses to the EOHHS Property and the Third Party Property as described herein.

c. All data acquired by the Contractor from EOHHS or from others 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 times to all such data, regardless of whether the data is stored by the Contractor or, where applicable, its Subcontractors.

d. 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.

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 thereunder.

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.

M. 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.

N. 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. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

O. No Third-Party Rights or Enforcement

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

P. Corrective Action Plan

If, at any time, EOHHS reasonably determine 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 will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by EOHHS. Failure to implement the corrective action plan may subject the Contractor to termination of the

Contract by EOHHS as described in **Section 5.7**, or other intermediate sanctions as described in **Section 5.5.Q**.

Q. Intermediate Sanctions

1. In addition to termination under **Section 5.7**, EOHHS may, in their sole discretion, impose any or all of the sanctions in **Section 5.5.Q.2** upon any of the events below; provided, however, that EOHHS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Before imposing any sanction, EOHHS shall give the Contractor timely written notice that explains the basis and nature of the sanction. Sanctions may be imposed in accordance with this section if the Contractor:
    a. Fails substantially to provide Covered 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;
    d. Misrepresents or falsifies information provided to CMS or EOHHS;
    e. Misrepresents or falsifies information provided to Enrollees, MassHealth Members, or its 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 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 management requirements consistent with **Section 2.9**;
    k. Fails to comply with any corrective action plan required by EOHHS;
    l. Fails to comply with financial solvency requirements;
    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. Fails to comply with reporting requirements;
    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 2.13** and **Appendices I** and **O**;

q. Fails to achieve the minimum Medicaid-only MLR set in **Section 2.13.Q.1.c**; or

r. Fails to comply with any other requirements of this Contract.

2. In accordance with 42 CFR 438.700 and 42 CFR 438.702, sanctions may include, but are not limited to:

   a. Civil money penalties in accordance with 42 CFR 438.704;

   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 USC §1396 u-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;

   g. Disenrollment of Enrollees;

   h. Service Area limitations;

   i. Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance;

   j. Deducting and withholding a percentage of the Contractor's Capitation Payment; and

   k. Such other measures as EOHHS determines appropriate to address the violation.

3. If EOHHS has identified a deficiency in the performance of a Subcontractor and the Contractor has not successfully implemented an approved corrective action plan in accordance with **Section 5.5.P**, EOHHS may:

   a. Require the Contractor to subcontract with a different Subcontractor deemed satisfactory by EOHHS; or

   b. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

4. In accordance with 42 CFR.438.726, capitation payments to the Contractor will be denied by EOHHS for new Enrollees when, and for so long as, payment for those Enrollees is denied to EOHHS by CMS under 42 CFR 438.730(e):

   a. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.5.Q.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 5.5.Q.1.a-f** of this Contract is not timely contested by the Contractor under 42 CFR 438.730(c).

c. For the purposes of this subsection, 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)).

5. In the event that EOHHS seeks to impose an intermediate sanction solely because the Contractor engaged in the conduct described in **Section 5.5.Q.1.m** (failure to comply with any other requirements of sections 1903(m) or 1932 of the Medicaid Act), EOHHS may impose only the following sanctions:
   a. Granting Enrollees the right to disenroll without cause and notifying the affected Enrollees of their right to disenroll;
   b. Suspending all new enrollments, including default enrollment, after the effective date of the sanction; and/or
   c. Suspending payments for all Enrollees who enroll 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.
6. Overpayment Capitation Deduction
   a. In accordance with **Section 5.2.B**, if the Contractor identifies an overpayment prior to EOHHS and does not recover such overpayment within 180 days after identification, without providing sufficient justification, as determined by EOHHS, in the Summary of Provider Overpayments report to EOHHS, EOHHS may apply a Capitation Payment deduction in an amount equal to the overpayment identified but not collected;
   b. In accordance with **Section 5.2.B**, if EOHHS identifies an overpayment prior to the Contractor such that the Contractor did not identify and report such overpayment to EOHHS in accordance with all applicable Contract requirements, including but not limited to the Summary of Provider Overpayments Report, within 180 days of the date(s) of service associated with any Claim(s) included in the overpayment:
      1) In the event the Contractor recovers such overpayment as agreed upon by EOHHS and the Contractor within 90 days of the Contractor's response to EOHHS's notification of the overpayment, EOHHS may apply a Capitation Payment deduction equal to 80% of the agreed-upon overpayment amount. No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.
      2) In the event the Contractor does not recover such overpayment first identified by EOHHS within 90 days of the Contractor's response to EOHHS's notification of the overpayment, without providing sufficient justification to EOHHS for any initial overpayment amounts identified but not recovered as determined by the sole discretion of EOHHS, EOHHS may apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected. No Capitation Payment

deductions shall apply to any amount of a recover to be retained under the False Claims Act cases or through other investigations.

c. EOHHS shall calculate, following the end of the Contract Year, any and all Capitation Payment deductions for the prior Contract Year pursuant to this **Section 5.4.Q**.

d. Notwithstanding the Capitation Payment deductions 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 report overpayments as specified in this Contract, including those requirements set forth in **Section 5.2.B**.

7. Before imposing any of the intermediate sanctions specified in this section, 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.

R. Additional Administrative Procedures

EOHHS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda as may be issued from time to time.

S. Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

T. Conflict of Interest

1. Neither the Contractor nor any Subcontractor may, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract, or that may be otherwise anticompetitive.
2. In accordance with 42 U.S.C. § 1396u-2(d)(3) and 42 CFR 438.58, EOHHS will implement safeguards against conflicts of interest on the part of its officers and employees who have responsibilities relating to the Contractor or any Subcontractor that are at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy (41 U.S.C. § 423).

U. Insurance for Contractor's Employees

The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance

coverage. The Contractor must, at the request of EOHHS, provide certification of professional liability insurance coverage.

V. Key Personnel

If the Contractor wishes to substitute another individual for the Director of the Senior Care Options Program, identified in **Section 2.2**, the compliance officer, identified in **Section 5.2.B.1.b**, or the medical director, identified in **Section 2.9.C.2.b**, the Contractor must notify EOHHS and CMS immediately and provide the name of a suitable replacement. Upon EOHHS or CMS request, the Contractor must provide EOHHS and CMS with the resumé of the proposed replacement and offer EOHHS and CMS an opportunity to interview the person. If EOHHS and CMS are not reasonably satisfied that the proposed replacement has ability and experience comparable to the originally approved personnel, EOHHS and CMS will notify the Contractor within 10 business days after receiving the resumé and completing any interview. The Contractor must then propose another replacement for approval. This process must be repeated until EOHHS and CMS approve new key personnel.

If EOHHS and CMS are concerned that the Director of the Senior Care Options Program, identified in **Section 2.2**, the compliance officer, identified in **Section 5.2.B.1.b**, or the medical director, identified in **Section 2.9.C.2.b** is not performing responsibilities required by this Contract, EOHHS and CMS will inform the Contractor of this concern. The Contractor must investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS and CMS of such actions. If the Contractor's actions fail to ensure full compliance with the terms of this Contract, as determined by EOHHS and CMS, the corrective action provisions in **Section 5.5.P** will be invoked by EOHHS and CMS.

W. Waiver

The Contractor, EOHHS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, EOHHS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by EOHHS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

X. Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

Y. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law,

or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. EOHHS must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If EOHHS paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to EOHHS. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Section 5.6 Record Retention, Inspection, and Audit

A. The Contractor, and its subcontractors, shall maintain all records and documents relating to activities or work under this Contract for a period of no less than 10 years.

B. 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, shall have the right, at any time, to inspect and audit any records or documents of the Contractor or its subcontractors, and, at any time, to inspect the premises, physical facilities, and equipment where activities or work related to this Contract is conducted. The right to audit under this section exists for 10 years from the last day of this Contract or from the date of completion of any audit, whichever is later.

C. The Secretary, the U.S. Department of Health and Human Services, EOHHS, the Governor of the Commonwealth of Massachusetts, or the State Auditor, or any of their designees, may inspect and audit any books or records of the Contractor or its subcontractors pertaining to:

1. The Contractor’s ability to bear the risk of potential financial losses; or
2. The services performed or determination of amounts payable amounts under this Contract.

Section 5.7 Termination of Contract

A. Termination without Prior Notice

In the event the Contractor fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or MassHealth programs, EOHHS may take any or all action under this Contract, law,

or equity. Without limiting the above, if EOHHS determine that the continued participation of the Contractor in the Medicare or MassHealth program may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or MassHealth program, EOHHS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity.

B. Termination with Prior Notice

Any party may terminate this Contract without cause upon no less than 180 days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. If EOHHS is the terminating party, and the termination is pursuant to EOHHS's authority under 42 CFR 438.708, such notice must include the reason for termination and the time and place of the pre-termination hearing pursuant to 42 CFR 438.710(b)(1).

C. Continued Obligations of the Parties

1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contactor otherwise withdraws from the Medicare or MassHealth programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that EOHHS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.
2. In the event that this Contract is terminated, expires, or is not renewed for any reason:
    a. If EOHHS, or both, elect to terminate or not renew the Contract, EOHHS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive medical care. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;
    b. The Contractor must promptly return to EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and
    c. The Contractor must supply to EOHHS all information necessary for the payment of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

D. Termination Pursuant to 42 CFR 438.708; Pre-Termination Hearing

In accordance with 42 CFR 438.710 (b), EOHHS will provide the Contractor with a pre-termination hearing, if the reason for the termination of the Contract is because the Contractor either: a) failed to carry out the substantive terms of its contract or b) failed to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Medicaid Act.

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 5.7.C.2.a.** of this Contract.
3. If EOHHS terminates this Contract, EOHHS and the Contractor shall comply with all Continuing Obligations set forth in **Section 5.7.C** of this Contract.

Section 5.8 Order of Precedence

A. The following documents are incorporated into and made a part of this Contract:

1. **Appendices A through P** to this Contract; and
2. Any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties.

B. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

1. The Contract terms and conditions;
2. **Appendices A through P** to this Contract; and
3. Any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties.

Section 5.9 Contract Term

This Contract shall be in effect from January 1, 2016, through December 31, 2024. At the option of EOHHS, the Contract may be extended in one-year increments through December 31, 2025. EOHHS may exercise its extension option by providing written notice to the Contractor of its intent to do so at least sixty (60) days prior to the expiration of the Contract term. The extension shall be under the same terms and conditions as the initial terms.

Section 5.10 Amendments

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 federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

Section 5.11 Service Area Expansions

A. The Contractor may request to EOHHS to expand the Contractor's Service Area as described in **Section 5.11.B** below; all such requests must be in accordance with **Sections 5.11.C** and **5.11.D** below:

B. From 2019 onward, the Contractor may request to EOHHS to expand the Contractor's Service Area to:

1. Include all or part of Berkshire, Dukes, Franklin, and/or Nantucket Counties.
2. Allow expansion from partial to full counties. The Contractor shall provide to EOHHS any information requested by EOHHS in the course of its review of the Contractor's requested Service Area expansion.

C. The Contractor shall:

1. Notify EOHHS in writing of its intent to pursue a Service Area Expansion (SAE) by submitting to EOHHS the Contractor's annual Notice of Intent to Apply submitted to CMS, no less than 2 weeks following its submission to CMS.
2. Receive in writing EOHHS' approval to proceed with the Service Area Expansion prior to the annual date upon which the Medicare application for SAEs is due to CMS;
3. Upon request, provide to EOHHS all documentation submitted to CMS regarding such SAEs; and
4. Provide to EOHHS all information EOHHS deems necessary to complete a review of network adequacy, staffing requirements, and other such implementation requirements as EOHHS shall determine necessary in order to deem the expanded Service Area ready prior to the Contractor accepting Enrollments in such Service Area.

D. EOHHS may, in its sole discretion, grant in full, grant in part, or reject the Contractor's requested Service Area expansion, including for the purpose of limiting the total number of SCO plans operating in each County. In the event that EOHHS grants the Contractor's requested Service Area expansion, whether in full or in part, the Parties shall amend **Appendix H** accordingly.

Section 5.12 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:

Leslie Darcy, Director, Office of Long Term Services and Supports

MassHealth Office of Long Term Services and Supports

One Ashburton Place, 5th floor

Boston, MA 02108

With copies to:

General Counsel

Executive Office of Health and Human Services

One Ashburton Place, 11th floor

Boston, MA 02108

To the Contractor:

Steven Belec

Commonwealth Care Alliance, Inc.

30 Winter Street

Boston, MA 02108

APPENDIX A. COVERED SERVICES

The Contractor is responsible for providing the following Medicare and Medicaid Covered Services, as authorized by the Primary Care Physician or the Primary Care Team, in accordance with the clinical protocols developed by the Contractor. The Contractor may offer additional services, in accordance with clinical protocols developed by the Contractor.

Ambulatory Surgery — all outpatient surgical services and related diagnostic and medical services.

Adult Day Health — community-based services such as nursing, assistance with activities of daily living, social, therapeutic, recreation, nutrition at a site outside the home, and transportation to a site outside the home.

Adult Foster Care/Adult Group Care — daily assistance in personal care, managing medication, meals, snacks, homemaking, laundry, and medical transportation.

Audiologist — audiologist exams and evaluations. See related hearing aid services.

Behavioral Health Services — see **Appendix A**, **Exhibit 1**.

Chiropractic Services — chiropractic manipulative treatment and radiology services.

Community-Based Services — including but not limited to the following services: homemaker; personal care; respite care; dementia and social day care; environmental accessibility adaptations; transportation; chore and companion; and respite.

Day Habilitation — a structured, goal-oriented, active treatment program of medically oriented, therapeutic and habilitation services for developmentally disabled individuals who need active treatment.

Dental Services — including but not limited to the following services: emergency care visits, including X rays; extractions; dentures; and oral surgery.

Dialysis — including: laboratory; prescribed drugs; tubing change; adapter change; hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis; and training related to dialysis services.

Durable Medical Equipment (DME) and Medical/Surgical Supplies

1. **Durable medical equipment** — products that are: (a) fabricated primarily and customarily to fulfill a medical purpose; (b) generally not useful in the absence of illness or injury; (c) able to withstand repeated use over an extended period of time; and (d) appropriate for home use. Includes but is not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, and rentals),

walkers, commodes, special beds, monitoring equipment, orthotic and prosthetic devices, and the rental of Personal Emergency Response Systems (PERS). Coverage includes related supplies and repair and replacement of the equipment.

2. **Medical/surgical supplies** — medical/treatment products that: (a) are fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) are used in the treatment of a specific medical condition; and (c) are non-reusable and disposable. Includes but is not limited to items such as urinary catheters, wound dressings, glucose monitors, and diapers.

Emergency Services — covered inpatient and outpatient services, including behavioral health services, that are furnished to an Enrollee by a provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition. Emergency services include post-stabilization services provided after an emergency is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer.

Frail Elder Waiver services — services as described in the Frail Elder Waiver (as that term is defined in the Contract), to the extent that they are provided to a member enrolled in that waiver, and to the extent that such services are not duplicative of any services described elsewhere in this **Appendix A**.

Geriatric Support Services Coordination — services provided by a Geriatric Support Services Coordinator in accordance with **Subsection 2.4.A.5** of the Contract.

Hearing Aid Services — including but not limited to diagnostic services, hearing aids or instruments, and services related to the care and maintenance of hearing aids or instruments.

Home Health — all home health care services, including DME associated with such services; part-time or intermittent skilled nursing care and home health services; physical, occupational, and speech language therapy; and medical social services.

Hospice — a package of services such as nursing; medical social services; physician; counseling, including bereavement, dietary, spiritual, or other types of counseling; physical, occupational, and speech language therapy; homemaker/home health aide; medical supplies, drugs, biological supplies; and short term inpatient care.

Inpatient Hospital Services— all inpatient services, including but not limited to physician, surgery, radiology, nursing, laboratory, other diagnostic and treatment procedures, blood and blood derivatives, semi-private or private room and board, drugs and biologicals, medical supplies, durable medical equipment, and medical surgical/intensive care/coronary care unit, as necessary, at any of the following settings:

1. Acute inpatient hospital;

2. Chronic hospital;
3. Rehabilitation hospital; or
4. Psychiatric hospital.

Institutional Care — services such as nursing, medical social work, assistance with activities of daily living, therapies, nutrition, and drugs and biologicals provided at a skilled nursing facility or other nursing facility.

Laboratory — all services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Enrollees.

Long-Term Services and Supports — the services and supports set forth in **Appendix A, Exhibit 2**. These services 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.

Orthotics — braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body, including therapeutic shoes for Enrollees who have diabetic foot disease.

Oxygen and Respiratory Therapy Equipment — ambulatory liquid oxygen systems and refills; aspirators; compressor-driven nebulizers; intermittent positive pressure breather (IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental.

Personal Care Attendant Services — assistance with Activities of Daily Living (ADLs) such as bathing, dressing, grooming, eating, ambulating, toileting, and transferring.

Pharmacy — legend and non-legend drugs that are reasonable and necessary for the diagnosis or treatment of illness or injury. Legend drugs must also be approved by the U.S. Food and Drug Administration.

Physician (primary) — annual exams and continuing care, including medical, radiological, laboratory, anesthesia and surgical services.

Physician (specialty) — physician specialty services, including but not limited to the following list and second opinions upon the request of the Enrollee:

Anesthesiology	Neurology	Psychiatry
Audiology	Neurosurgery	Pulmonology
Cardiology	Oncology	Radiology
Dentistry	Ophthalmology	Rheumatology

Dermatology	Oral surgery	Surgery
Gastroenterology	Orthopedics	Thoracic surgery
Gynecology	Otorhinolaryngology	Vascular surgery
Internal Medicine	Podiatry	Urology
Nephrology		

Podiatry —care for medical conditions affecting the lower limbs, including routine foot care as defined by Medicare in Part III, Section 2323 of the Medicare Carriers Manual.

Private Duty Nursing — continuous, specialized skilled nursing services.

Prosthetic Services and Devices — prosthetic devices, including the evaluation, fabrication, and fitting of a prosthesis. Coverage includes related supplies, repair, and replacement.

Radiology and X-ray — all X-rays, including portable X-rays, magnetic resonance imagery (MRI), radiation therapy, and radiological services.

Therapy — individual treatment (including the design, fabrication, and fitting of an orthotic, prosthetic, or other assistive technology device), comprehensive evaluation, and group therapy.

1. **Physical** – evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems.
2. **Occupational** – evaluation and treatment of an Enrollee in his or her own environment for impaired physical functions.
3. **Speech and Hearing** – evaluation and treatment of speech, language, voice, hearing, fluency, and swallowing disorders.

Tobacco Cessation Services – face to face individual and group tobacco cessation counseling as defined at 130 CMR 433.435(B), 130 CMR 405.472 and 130 CMR 410.420 and pharmacotherapy treatment, including nicotine replacement therapy (NRT). This is in addition to any services that are covered by Medicare.

Transportation – ambulance (air and land), taxi, and chair car transport for medical reasons.

Vision Care Services – the professional care of the eyes for purposes of diagnosing and treating all pathological conditions. They include eye examinations, vision training, prescriptions, and glasses and contact lenses.

APPENDIX A EXHIBIT 1: BEHAVIORAL HEALTH SERVICES

A. Inpatient Services - twenty-four-hour services that provide medical intervention for mental health or substance abuse diagnoses, or both, including:

1. **Inpatient Mental Health Services** - hospital services to stabilize an acute psychiatric condition that: 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or other; or 4) has resulted in marked psycho-social dysfunction or grave mental disability.
2. **Inpatient Substance Use Disorder Services (Level IV)** - hospital services that provide a detoxification regimen of medically directed evaluation, care and treatment for psychoactive substance –abusing Enrollees in a medically managed setting.

B. Diversionary Services — those BH services that are provided as alternatives to inpatient services, including:

1. **Community Support** - services provided in a community setting, which are used to prevent hospitalization, and designed to respond to the needs of Enrollees whose pattern of utilization of services or clinical profile indicates high risk of readmission into 24-hour treatment settings.
2. **Community Crisis Stabilization** — services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for individuals who do not require Inpatient Services.
3. **Observation/Holding Beds** — services to provide hospital level care for up to 24 hours to provide time for assessment, stabilization, and identification of appropriate resources for individuals.
4. **Partial Hospitalization** — an alternative to Inpatient Mental Health Services which offers short-term day mental health programming available seven days per week consisting of therapeutically intensive acute treatment within a stable therapeutic milieu and including daily psychiatric management.
5. **Psychiatric Day Treatment** — services that constitute a program of a planned combination of diagnostic, treatment, and rehabilitative services provided to mentally or emotionally disturbed persons who need more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual provider's office, or hospital outpatient department, but who do not need full-time hospitalization or institutionalization.
6. **Structured Outpatient Addiction Program (SOAP)** - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured

treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning.

7. **Intensive Outpatient Program (IOP)** - a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.
8. **Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)** — 24 hour, seven days a week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducation groups; and discharge planning. Enrollees with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions These services may be provided in licensed freestanding or hospital – based programs.
9. **Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)** — 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.
10. **Effective January 1, 2024, Adult Residential Rehabilitation Services (RRS) for Substance Use Disorders (Level 3.1)** –

    24- hour residential environment that provides a structured and comprehensive rehabilitative environment that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.
11. Effective January 1, 2024, **Program of Assertive Community Treatment (PACT)** – a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered

Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.

C. BH Emergency Services - Medically necessary services that are available seven days per week, 24 hours per day to provide treatment of any Enrollee who is experiencing a mental health or substance abuse problem, or both, including:

1. Emergency Screening Services — a face-to-face assessment, conducted by appropriate clinical personnel, of an individual presenting with an emergency in a home, residential program, clinic, hospital emergency room, police station, and other settings.
2. Medication Management Services — assessment for and prescribing of medication by qualified personnel as a component of emergency services.
3. Short Term Crisis Counseling — provision of individual therapy as a component of emergency services.
4. Short-Term Crisis Stabilization Services — any or all of the following: (1) Crisis Stabilization; (2) Observation/Holding Beds; (3) Specialing Services; (4) Medication Management Services; and (5) Short-Term Crisis Counseling.
5. Specialing Services — therapeutic services provided to an individual, in a variety of settings, on a one-to-one basis to maintain the individual's safety as a component of BH Emergency Services.

D. Outpatient Services - mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner’s office.

1. **Standard Outpatient Services** – those Outpatient Services most often provided in an ambulatory setting.
    a. **Family Consultation** - a meeting of at least 15 minutes’ duration, either in person or by telephone, with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee’s treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual’s progress; or revise the treatment plan, as required.
    b. **Case Consultation** - an in-person or by telephone meeting of at least 15 minutes’ duration, between the treating Provider and other behavioral health clinicians or the Enrollee’s primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual’s progress; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.

c. **Diagnostic Evaluation** - an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.

d. **Dialectical Behavioral Therapy (DBT)** - a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Enrollees with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.

e. **Psychiatric Consultation on an Inpatient Medical Unit** - an in- person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.

f. **Medication Visit** - an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.

g. **Couples/Family Treatment** - the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.

h. **Group Treatment** – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.

i. **Individual Treatment** - the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.

j. **Inpatient-Outpatient Bridge Visit** - a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.

k. **Acupuncture Treatment** - the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.

l. **Opioid Replacement Therapy** - medically monitored administration of methadone, Buprenorphine, or other U.S. Food and Drug Administration (FDA)-approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This

service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.

m. **Ambulatory Detoxification (Level II.d)** - outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Detoxification is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.

n. **Psychological Testing** - the use of standardized test instruments to assess an Enrollee's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.

o. **Recovery Coaching** - (effective March 1, 2018) a non-clinical service provided by individuals currently in recovery from a substance use disorders and who have been trained to help people struggling with a similar experience (their peers) to gain hope, explore recovery and achieve life goals. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Enrollees to recovery community and serving as a personal guide and mentor.

p. **Recovery Support Navigators (RSN)** – (effective March 1, 2018) specialized care coordination services intended to engage Enrollees in accessing substance use disorder treatment, facilitating smooth transitions between levels of care, support Enrollees in obtaining service that facilitate recovery. Recovery Support Navigators coordinate with other substance use disorder treatment providers, as well as primary care and prescribers of medications for addiction therapy (MAT) in support of Enrollees.

E. Effective January 1, 2023, **Adult Community Crisis Stabilization (ACCS)** - ACCS is a community-based program that serves a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides 24-hour, short-term, staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and treatment include the capacity to provide induction onto and bridging for medications for the treatment of opioid use disorder (MOUD and withdrawal management for opioid use disorders (OUD) as clinically indicated. The ACCS program is an integrated part of the CBHC model.

F. Effective January 3, 2023, **Adult Mobile Crisis Intervention (AMCI) (formerly known as Emergency Services Program (ESP))** - AMCI provides adult community-based Behavioral Health crisis assessment, intervention, stabilization and follow-up for up to three days. AMCI services are available 24/7/365 and are

co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences), and provided via Telehealth to individuals age 21 and older when requested by the member or directed by the 24/7 BH Help Line and clinically appropriate. AMCIs operate ACCS programs with a preference for co-location of services. AMCI services must have capacity to accept adults voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

G. (Until January 3, 2023) Emergency Services Program (ESP) - services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.

1. ESP Encounter - each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization.
    a. Assessment - a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;
    b. Intervention –the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and
    c. Stabilization – short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.

In addition, medication evaluation and specialing services shall be provided if Medically Necessary.

H. Special Procedures

1. **Electro-Convulsive Therapy** — service that initiates seizure activity with an electric impulse while the Enrollee is under anesthesia. It is administered in a hospital facility that is licensed to provide this service by the Department of Mental Health.
2. **Psychological Neuropsychological Testing** — the use of standardized test instruments when indicated for behavioral or physical health reasons to evaluate aspects of an Enrollee's functioning, including but not limited to cognitive processes, emotional conflicts, and type and degree of psycho-pathology.

APPENDIX A EXHIBIT 2: LONG-TERM SERVICES AND SUPPORTS

Adult Day Health

Adult Foster Care

Day Habilitation

The services described in the Frail Elder Waiver, except for those described at 651 CMR 3.02, subparagraph (l) of the definition of Home Care Program Services, to the extent that such services are provided to a member enrolled in that waiver, and to the extent that such services are not duplicative of any services described elsewhere in this **Appendix A, Exhibit 2**.

Hospice

Institutional Care, including Chronic and Rehabilitation Hospitals

Personal Care Attendant Services

Private Duty Nurse

APPENDIX A EXHIBIT 3: DIGITAL THERAPY PRODUCTS

Digital Therapy Products - Digital therapy products designated by EOHHS. Such digital therapy products, even though such products are non-covered services, must be listed on Contractor's formulary in the same manner as listed on the MassHealth Drug List, with the same prior authorization status, point of sale (POS) rules, age restrictions, step therapy, quantity limit and diagnostic restrictions as MassHealth FFS. Claims for digital therapy products designated by EOHHS, which are non-covered services, must be processed through the Contractor's on-line pharmacy claims processing system and be paid to the pharmacy at $0 pay, with $0 cost sharing for members.

APPENDIX A EXHIBIT 4

COMMUNITY BEHAVIORAL HEALTH CENTER (CBHC) PROVIDER LIST

CBHC	CATCHMENT AREA
North Suffolk Mental Health Association	Greater Boston
Cambridge Health Alliance	Boston/Cambridge
Boston Medical Center	Boston/Brookline
Riverside Community Care	Norwood
Aspire Health Alliance	South Shore
The Brien Center	Berkshires
Clinical Support Options	Greenfield
Clinical Support Options	Northampton
Behavioral Health Network (BHN)	Southern Pioneer
Center for Human Development	Southern Pioneer
Advocates	Metrowest
Clinical Support Options	North County
Community Healthlink	North County
Riverside Community Care	South County
Community Healthlink	Worcester
Eliot Community Health Services	North Essex
Beth Israel Lahey Behavioral Services	Lawrence
Vinfen	Lowell
Eliot Community Health Services	Tri-city
Child and Family Services	Southern Coast
High Point Treatment Center	Brockton
Bay Cove Human Services	Cape Cod
Fairwinds- Nantucket's Counseling Center	Nantucket
Child and Family Services	Fall River
Community Counseling of Bristol County	Taunton Attleboro

APPENDIX B: REQUIRED INFORMATION TO BE INCLUDED IN THE EVIDENCE OF COVERAGE

A. Welcome and Overview of SCO

B. Features of SCO

a. Primary Care Physician
b. Primary Care Team
c. One Source for All Your Care
d. Facilities
e. Coordination of Services with Medicare and Medicaid
f. Services Provided Exclusively through SCO

C. Eligibility

D. Enrollment

a. Step 1: Intake
b. Step 2: Assessment
c. Step 3: Preliminary Approval
d. Step 4: Final Approval and Enrollment
e. Appeals Process

E. Benefits and Coverage

a. Outpatient Health Services
b. Inpatient Hospital Care
c. Nursing Home Care
d. Home Health Care
e. End-of Life Care
f. Health-Related Services
g. Dental Care
h. Long-Term Services and Supports

F. Exclusions and Limitations

G. Access to After-Hours Care and Emergency Care

a. After-Hours Care
b. Emergency Care
c. Out-of-Area Urgently Needed Care

H. Complaints and Appeals (in accordance with 42 CFR 438.100)

a. Complaint Process
b. Appeals Process
c. You Have a Right to Appeal
d. Support for Your Appeal
e. Who May File an Appeal
f. If You Want Someone to File an Appeal for You
g. Help with Your Appeal

I. Your Rights as an Enrollee (in accordance with 42 CFR 438.100)

a. The extent to which, and how, Enrollees may obtain benefits, including family planning services, from out of network providers.

J. Other Contract Provisions

a. Termination Benefits
b. Voluntary Disenrollment
c. Involuntary Disenrollment
d. Renewal Provisions
e. Changes to Your Contract
f. Continuation of Services after Termination
g. Cooperation from You
h. Governing Law
i. Assignment of Benefits
j. Notifications
k. Notice of Certain Events
l. Policies and Procedures Adopted by the SCO
m. Time Limitations on Claims
n. Access to Your medical Records
o. Waiver of Conditions for Care
p. Who Receives Payment under this Plan?

K. Information about Federal Mental Health Parity and Grievances (in accordance with 130 CMR 450.117(J))

L. Definitions

APPENDIX C: REQUIREMENTS FOR PROVIDER AGREEMENTS AND SUBCONTRACTS

The Contractor shall:

A. Enter into Provider Agreements only with qualified or licensed providers who meet federal and State requirements when applicable;

B. Maintain a supplier/vendor management program that proactively requires the Contractor's major Providers of services (for example, hospitals, pharmacies, home health providers, laboratory services, and radiology services) to conduct activities to monitor the quality, access, and cost-effectiveness of their services and identify and address opportunities for improvement on an ongoing basis. In addition, management and clinical data from the Provider must be submitted to the Contractor in a format compatible with the Contractor's information systems. (Such data must be incorporated with the Contractor's utilization and cost data and submitted to EOHHS where required under the Contract.);

C. Maintain all Provider Agreements and other agreements and subcontracts relating to this Contract 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;

D. Actively monitor the quality of care provided to Enrollees under any Provider Agreements and any other subcontracts;

E. Remain fully responsible for meeting all of the terms and requirements 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;

F. Prior to any delegation to a Subcontractor, evaluate the prospective Subcontractor’s ability to perform the activities to be delegated;

G. Have a written agreement with any Subcontractor that specifies the activities and report responsibilities delegated to the Subcontractor and provides for revoking delegation or imposing other sanctions if the Subcontractor’s performance is inadequate;

H. Monitor any Subcontractor’s performance on an ongoing basis and subject it to formal review annually. If any deficiencies or areas for improvement are identified, the Contractor and the Subcontractor shall take corrective action. Upon request, the Contractor shall provide EOHHS with a copy of such annual review and any corrective action plans developed as a result;

I. Notify EOHHS in writing at least 60 days prior to procurement or reprocurement of services provided by any Subcontractor;

J. Provide EOHHS with information, in response to all questions posed by EOHHS, regarding implementation plans to ensure readiness for transition to a new Subcontractor;

K. Notify EOHHS in writing immediately upon notifying any Subcontractor or being notified by any Subcontractor of the intention to terminate such subcontract;

L. Inform EOHHS if any of its Subcontractors are certified Minority Business Enterprises;

M. Ensure that all Provider Agreements include the following provision: "Providers shall not seek or accept payment from any Enrollee for any SCO Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any SCO Covered Service rendered to an Enrollee. Instead, Providers shall look solely to (Contractor's name) for payment with respect to SCO 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 (Contractor's name) for any reason, even in the event that (Contractor's name) fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of its agreement with the Provider or any other agreement entered into by (Contractor's name)."

N. Ensure that all Provider Agreements and subcontracts contain at least the following provisions:

1. Specification that the subcontract be governed by and construed in accordance with all laws, regulations, and contractual obligations incumbent upon the Contractor, including any applicable requirements specified in the Contract;
2. Subcontractor's agreement to accept the Contractor's payment as payment in full and not to bill Enrollees, EOHHS or CMS;
3. Subcontractor's agreement to hold harmless EOHHS, CMS, and Enrollees in the event that the Contractor cannot or will not pay for services performed by the Subcontractor pursuant to the subcontract;
4. Subcontractor's agreement that assignment or delegation of the subcontract is prohibited unless prior written approval is obtained from the Contractor; and
5. Subcontractor's agreement to make all books and records, pertaining to the goods and services furnished under the terms of the subcontract, available for inspection, examination, or copying by EOHHS and CMS.

O. Provide adequate and appropriate stop-loss protection if incentive arrangements with the subcontractor place the subcontractor at substantial financial risk for services it does not provide; and

P. Make best efforts to ensure that all subcontractor agreements stipulate that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the Subcontractor is based

APPENDIX D: REPORTING REQUIREMENTS

The Contractor must report performance, as required by the Contract, to EOHHS and CMS through financial statements and ratios, using the financial indicators and according to the definitions below. These indicators are intended to measure the liquidity, efficiency, composition, capitalization, and profitability of the Contractor, in accordance with generally accepted accounting principles. The Contractor must provide financial and other reports to EOHHS and CMS as directed by EOHHS and CMS, including documentation and an explanation of any deviations from the standards as defined below. All reports must be inclusive of data from subcontractors. All data must be related to the specific entity which directly operated the Senior Care Options Program (i.e., not the parent organization or affiliate).

The Contractor shall submit the reports below as specified:

A. Immediately

1. Notify EOHHS when the Contractor has reason to consider insolvency or otherwise has reason to believe it or any subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the Contractor's board of the potential for insolvency. (**Section 2.11.B**)
2. Notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency. (**Section 2.11.C**)

B. Monthly, to EOHHS and CMS:

1. Number and types of grievances and appeals filed by Enrollees as well as how and in what time frames they were resolved in accordance with **Section 2.13.D**. Reports should include relevant information from the annual analysis of Enrollee Surveys in accordance with **Section 2.12.C**.
2. Encounter data in accordance with **Section 2.13.B**.
3. Enrollee-level risk score data, at the direction of and in a format prescribed by EOHHS.
4. Excluded Provider Monitoring Report as described in **Section 2.5.B.1.f.1.d**.
5. Claims processing report on timely payment to Providers as set forth in **Section 5.1.I**.

C. Quarterly, to EOHHS and CMS:

1. Financial data related to cost for the Massachusetts SCO covered population.

The report shall be submitted in a form and format specified by EOHHS including, but not limited to, the following:

a. Member Enrollment and Disenrollment
b. Balance Sheet containing the SCO product line net worth and working capital as set forth in **Section 2.11.A**
c. Income Statement
d. Cash Flow;
e. Financial Indicators
f. Utilization
g. Solvency Requirements as set forth in **Section 2.11.B**
h. Financial to encounter submission reconciliation

2. Submit to EOHHS the list of Community Support Programs for Individuals with Justice Involvement Provider in accordance with **Section 2.4.D.10**.

D. Annually for the prior calendar year, to EOHHS and CMS:

1. Annual Financial Reports:
   a. Annual Audited Financial Statements

      The Contractor shall provide EOHHS with the Contractor's annual audited financial statements prepared in accordance with the American Institute of Certified Public Accountants (AICPA) standards (see **Section 2.11.C**). Audits must include:

      1) Opinion of a certified public accountant;
      2) Statement of revenues and expenses;
      3) Balance sheet;
      4) Statement of cash flows;
      5) Explanatory notes;
      6) Management letters;
      7) Statements of changes in net worth; and
      8) IBNR (incurred but not reported) actuarial statement for the most recent fiscal year period.

   b. Plan Specified Supplemental Reports – related to annual cost for the Massachusetts
      1) Member Enrollment

2) Income – by the specific MassHealth Rate Cells (RC's), primary payer (Medicare/Medicaid), region, and dual eligible status

3) Medical Loss Ratio –

a) Blended Medicaid/Medicare

b) Medicare Only

c) Medicaid Only

c. Plan Specified Enrollment and Financial Projections

The Contractor shall provide plan specific enrollment and financial projections, including:

1) Enrollment projections by the specific MassHealth Rate Cells (RC's), primary payer (Medicare/Medicaid), region, and dual eligible status

2) Plan specified financial projections for a minimum of one year from the date of the latest submitted financial statement using the accrual method of accounting in conformity with generally accepted accounting principles. Describe financing arrangements and include all documents supporting these arrangements for any projected deficits. Provide evidence of financing arrangements for any projected deficit.

d. Medical Loss Ratio Report in accordance with **Section 2.13.Q**.

2. Non-Financial Reports:

a. The Contractor's credentialing policies and procedures, if amended, including demonstration to EOHHS that all Providers within the Contractor's Provider Network are credentialed according to such policies and procedures in accordance with **Section 2.5.B.1**.

b. Progress toward reaching established quality management goals in accordance with **Section 2.9** and on the schedule established in **Appendix L**.

c. HEDIS measures (clinical indicator data) in accordance with **Section 2.13.A**.

d. A copy of the Contractor's NCQA-approved model of care, and any changes to the model of care for the Enrollees who are not Dual Eligible.

e. Certification checklist attesting that the Contractor has implemented the actions necessary to comply with **Section 2.5.B.1.e.4**.

f. Claims processing annual report on timely payment to providers as set forth in **Section 5.1.I**.

g. List of all current Subcontractors in accordance with **Section 2.5.C.3.g**.

h. Summary Report of For-Cause Provider Suspensions and Terminations

i. Summary of Provider Overpayments (semi-annual)

j. Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan

k. Payment Suspension (Quarterly)

3. Provide EOHHS an annual summary of Serious-Reportable Events (SREs) and Provider Preventable Conditions (PPCs), including the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE and PPC in accordance with **Section 2.5.G**.

E. Other Medicare Advantage Financial Reports at 42 CFR 422.502 and 516

F. Ad Hoc

1. The Contractor shall notify EOHHS and CMS of SRE's, including the resolution of each SRE, if any and any next steps to be taken with respect to each SRE. The Contractor must continue to report SRE's upon discovery as previously required in accordance with **Section 2.5.G**.

APPENDIX E EXHIBIT 1: BASE CAPITATION RATES

Base Capitation Rates for January 1, 2022, through June 30, 2022

(Subject to CMS Approval)

	Community Settings of Care			Institutional Settings of Care		
	Other	AD/CMI	NHC	Tier 1	Tier 2	Tier 3
Dually Eligible Greater Boston	RC 20 $ 551.59	RC 22 $ 769.43	RC 24 $ 2,493.59	RC 26 $ 4,841.40	RC 27 $ 7,249.19	RC 28 $ 8,760.72
Dually Eligible Outside Greater Boston	RC 21 $ 608.11	RC 23 $ 733.70	RC 25 $ 2,635.25	RC 26 $ 4,841.40	RC 27 $ 7,249.19	RC 28 $ 8,760.72
MassHealth Only, Greater Boston	RC 30 $ 1,088.27	RC 32 $ 1,779.60	RC 34 $ 3,824.19	RC 36 $ 4,841.40	RC 37 $ 7,249.19	RC 38 $ 8,760.72
MassHealth Only, Outside Greater Boston	RC 31 $ 1,235.30	RC 33 $ 1,710.61	RC 35 $ 3,888.75	RC 36 $ 4,841.40	RC 37 $ 7,249.19	RC 38 $ 8,760.72

Base Capitation Rates + HCBS/BH Add-On for July 1, 2022, through December 31, 2022

(Subject to CMS Approval)

	Community Settings of Care			Institutional Settings of Care		
	Other	**AD/CMI**	**NHC**	**Tier 1**	**Tier 2**	**Tier 3**
Dually Eligible Greater Boston	**RC 20** **$ 550.21**	**RC 22** **$ 767.74**	**RC 24** **$ 2,458.54**	**RC 26** **$ 4,845.91**	**RC 27** **$ 7,255.93**	**RC 28** **$ 8,768.87**
Dually Eligible Outside Greater Boston	**RC 21** **$ 607.27**	**RC 23** **$ 732.01**	**RC 25** **$ 2,587.05**	**RC 26** **$ 4,845.91**	**RC 27** **$ 7,255.93**	**RC 28** **$ 8,768.87**
MassHealth Only, Greater Boston	**RC 30** **$ 1,086.84**	**RC 32** **$ 1,783.07**	**RC 34** **$ 3,781.19**	**RC 36** **$ 4,845.91**	**RC 37** **$ 7,255.93**	**RC 38** **$ 8,768.87**
MassHealth Only, Outside Greater Boston	**RC 31** **$ 1,234.08**	**RC 33** **$ 1,711.59**	**RC 35** **$ 3,833.74**	**RC 36** **$ 4,845.91**	**RC 37** **$ 7,255.93**	**RC 38** **$ 8,768.87**

Base Capitation Rates for January 1, 2023, through June 30, 2023

(Subject to CMS Approval)

	Community Settings of Care			Institutional Settings of Care		
	Other	BH	NHC	Tier 1	Tier 2	Tier 3
Dually Eligible Eastern	RC 20 $425.17	RC 23 $823.18	RC 26 $2,588.96	RC 29 $5,114.85	RC 30 $7,669.52	RC 31 $9,209.34
Dually Eligible Western	RC 21 $401.19	RC 24 $828.60	RC 27 $2,598.67	RC 29 $5,114.85	RC 30 $7,669.52	RC 31 $9,209.34
Dually Eligible The Cape	RC 22 $374.68	RC 25 $781.07	RC 28 $2,593.13	RC 29 $5,114.85	RC 30 $7,669.52	RC 31 $9,209.34
MassHealth Only Eastern	RC 32 $935.34	RC 35 $1,692.46	RC 38 $4,042.76	RC 41 $5,114.85	RC 42 $7,669.52	RC 43 $9,209.34
MassHealth Only Western	RC 33 $837.47	RC 36 $2,027.76	RC 39 $4,306.19	RC 41 $5,114.85	RC 42 $7,669.52	RC 43 $9,209.34
MassHealth Only The Cape	RC 34 $1,106.29	RC 37 $2,084.35	RC 40 $4,550.12	RC 41 $5,114.85	RC 42 $7,669.52	RC 43 $9,209.34

Base Capitation Rates for July 1, 2023, through December 31, 2023

(Subject to CMS Approval)

	Community Settings of Care			Institutional Settings of Care		
	Other	BH	NHC	Tier 1	Tier 2	Tier 3
Dually Eligible Eastern	RC 20 $416.21	RC 23 $810.15	RC 26 $2,551.41	RC 29 $5,112.15	RC 30 $7,665.42	RC 31 $9,204.36
Dually Eligible Western	RC 21 $394.00	RC 24 $817.30	RC 27 $2,577.19	RC 29 $5,112.15	RC 30 $7,665.42	RC 31 $9,204.36
Dually Eligible The Cape	RC 22 $368.30	RC 25 $771.90	RC 28 $2,562.31	RC 29 $5,112.15	RC 30 $7,665.42	RC 31 $9,204.36
MassHealth Only Eastern	RC 32 $931.55	RC 35 $1,680.80	RC 38 $4,021.19	RC 41 $5,112.15	RC 42 $7,665.42	RC 43 $9,204.36
MassHealth Only Western	RC 33 $834.17	RC 36 $2,019.69	RC 39 $4,298.68	RC 41 $5,112.15	RC 42 $7,665.42	RC 43 $9,204.36
MassHealth Only The Cape	RC 34 $1,102.62	RC 37 $2,077.13	RC 40 $4,537.68	RC 41 $5,112.15	RC 42 $7,665.42	RC 43 $9,204.36

APPENDIX E EXHIBIT 2: RISK SHARING ARRANGEMENTS
Contract Year 2023

Contract-Wide Risk Sharing Arrangement (**Section 4.7.C.4**)

1. Gain scenario

   If the medical component of the Capitation Rate Payment as set forth in **Section 4.7.C.2** is greater than Actual Medical Expenditures as set forth in **Section 4.7.C.3**, then the Contractor will be in a "Gain for the Contract Year", with the "Gross Gain Amount for the Contract Year" defined as the difference between the medical component of the Capitation Rate Payment and the Actual Medical Expenditures. The Contractor and EOHHS will share the Gross Gain Amount for the Contract Year as set forth below:

   a. If the Gross Gain Amount for the Contract Year is less than or equal to 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 100% and the EOHHS share is 0%.

   b. If the Gross Gain Amount for the Contract Year is greater than 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 5% and the EOHHS share is 95%.

2. Loss scenario

   If the medical component of the Capitation Rate Payment as set forth in **Section 4.6.C.2** is less than Actual Medical Expenditures as set forth in **Section 4.7.C.3**, then the Contractor will be in a "Loss for the Contract Year", with the "Gross Loss Amount for the Contract Year" defined as the difference between the Medical Component of the Capitation Rate Payment and the Actual Medical Expenditures. The Contractor and EOHHS will share the Gross Loss Amount for the Contract Year as set forth below:

   a. If the Gross Loss Amount for the Contract Year is less than or equal to 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 100% and the EOHHS share is 0%.

   b. If the Gross Loss Amount for the Contract Year is greater than 5% of the Medical Component of the Capitation Rate Payment, the Contractor share is 5% and the EOHHS share is 95%.

APPENDIX F: CITIES AND ZIP CODES IN GREATER BOSTON REGION

City	Zip Code
Accord	02018
Allston	02134
Arlington	02474
Arlington	02476
Arlington Heights	02475
Babson Park	02457
Boston	02101
Boston	02102
Boston	02103
Boston	02104
Boston	02105
Boston	02106
Boston	02107
Boston	02108
Boston	02109
Boston	02110
Boston	02111
Boston	02112
Boston	02113
Boston	02114
Boston	02115
Boston	02116

City	Zip Code
Boston	02117
Boston	02118
Boston	02119
Boston	02120
Boston	02122
Boston	02123
Boston	02124
Boston	02125
Boston	02126
Boston	02127
Boston	02128
Boston	02129
Boston	02130
Boston	02131
Boston	02132
Boston	02133
Boston	02134
Boston	02135
Boston	02136
Boston	02137
Boston	02163
Boston	02196
Boston	02199
Boston	02201
Boston	02202
Boston	02203

City	Zip Code
Boston	02204
Boston	02205
Boston	02206
Boston	02207
Boston	02208
Boston	02209
Boston	02210
Boston	02211
Boston	02212
Boston	02215
Boston	02216
Boston	02217
Boston	02222
Boston	02228
Boston	02241
Boston	02266
Boston	02283
Boston	02284
Boston	02293
Boston	02295
Boston	02297
Boston	02455
Braintree	02184
Braintree	02185
Brighton	02135
Brookline	02445

City	Zip Code
Brookline	02446
Brookline Village	02447
Cambridge	02138
Cambridge	02139
Cambridge	02140
Cambridge	02141
Cambridge	02142
Cambridge	02163
Cambridge	02238
Cambridge	02239
Charlestown	02129
Chelsea	02150
Chestnut Hill	02467
Cohasset	02025
Dedham	02026
Dedham	02027
Dorchester	02121
Dorchester	02122
Dorchester	02124
Dorchester	02125
East Boston	02128
East Boston	02228
Greenbush	02040
Hingham	02018
Hingham	02043
Hingham	02044

City	Zip Code
Hull	02045
Hyde Park	02136
Hyde Park	02137
Jamaica Plain	02130
Mattapan	02126
Milton	02186
Milton Village	02187
Minot	02055
Newton	02458
Newton	02459
Newton	02460
Newton	02461
Newton	02462
Newton	02464
Newton	02465
North Scituate	02060
Norwell	02061
Norwood	02062
Quincy	02169
Quincy	02170
Quincy	02171
Quincy	02269
Randolph	02368
Readville	02136
Readville	02137
Revere	02151

City	Zip Code
Roslindale	02131
Roxbury	02118
Roxbury	02119
Roxbury	02120
Scituate	02040
Scituate	02055
Scituate	02060
Scituate	02066
Somerville	02143
Somerville	02144
Somerville	02145
Waban	02468
Waverley	02479
West Roxbury	02132
Westwood	02090
Weymouth	02188
Weymouth	02189
Weymouth	02190
Weymouth	02191
Winthrop	02152

Counties in Eastern, Western, and the Cape Regions

County	Region
Bristol	Eastern
Essex	Eastern
Middlesex	Eastern
Norfolk	Eastern
Suffolk	Eastern
Berkshire	Western
Franklin	Western
Hampden	Western
Hampshire	Western
Worcester	Western
Barnstable	The Cape
Dukes	The Cape
Nantucket	The Cape
Plymouth	The Cape

Federally Required Disclosures

Ownership and Control, Business Transactions and Criminal Convictions

(42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3)

Federal law requires fiscal agents, managed care entities (MCEs), and other MassHealth providers, including applicants and certain bidders seeking to provide MassHealth services, to disclose some or all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3. MassHealth requires the submission of tax identification numbers (TINs), for example, social security number (SSN) or employer identification number (EIN), for purposes necessary to properly administer the MassHealth program (See 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405 (c)(1).) Unless otherwise instructed by MassHealth, fiscal agents, MCEs, and other providers, must use this form when disclosing such information to MassHealth.

The following terms are defined in 42 CFR 438.2.

- Health Insuring Organization (HIO)
- Managed Care Organization (MCO)
- Prepaid Ambulatory Health Plan (PAHP)
- Prepaid Inpatient Health Plan (PIHP)
- Primary Care Case Manager (PCCM)

I. Disclosing Entities

All providers, disclosing entities, and others completing this form must complete Sections IV.A. and IV.F. Other information that must be disclosed and the timing of the disclosure varies depending on the identity of the disclosing entity as specified below.

A. Providers and PCCMs

(1) Disclosures of Ownership and Control (Section IV.B.) are due

(a) upon submission of a provider application;

(b) upon execution of the provider agreement with MassHealth;

(c) upon MassHealth's request during revalidation of enrollment; and

(d) within 35 days after any change in ownership of the entity required to disclose.

(2) Disclosures of Business Transactions (Section IV.C.) are due within 35 days of MassHealth's written request.

(3) Disclosures of Criminal Convictions (Section IV.D.) are due

(a) upon submission of a provider application;

(b) upon execution or renewal of the provider agreement with MassHealth; and

(c) upon MassHealth's written request.

(4) Disclosures of Relationships to Excluded, Penalized or Convicted Persons (Section IV.E.) are due

(a) upon execution of a provider agreement with MassHealth;

(b) upon renewal of the provider agreement with MassHealth; and

(c) upon MassHealth's written request.

B. Provider applicants

Provider applicants must provide Ownership and Control and Criminal Conviction Disclosures, and Disclosures of Relationships of Excluded, Penalized, or Convicted Persons (Section IV. B, D, and E), as detailed above, however, they are not required to disclose Business Transactions (Section IV.C).

C. Fiscal agents

Disclosures of Ownership and Control (Section IV.B.) are due

(1) upon submission of a proposal in accordance with the state procurement process;

(2) upon execution of a contract with MassHealth;

(3) upon renewal or extension of the contract with MassHealth; and

(4) within 35 days after any change in ownership.

D. MCEs (MCOs, PIHPs, PAHPs, and HIOs except PCCMs)

(1) Disclosures of Ownership and Control (Section IV.B.) are due

(a) upon submission of a proposal in accordance with the state procurement process;

(b) upon execution of a contract with MassHealth;

(c) upon renewal or extension of the contract with MassHealth; and

(d) within 35 days after any change in ownership.

(2) Disclosures of Business Transactions (Section IV.C.) are due within 35 days of MassHealth's written request.

(3) Disclosures of Criminal Convictions (Section IV.D.) are due

(a) upon submission of a provider application;

(b) upon execution or renewal of the provider agreement with MassHealth; and

(c) upon MassHealth's written request.

(4) Disclosures of Relationships to Excluded, Penalized, or Convicted Persons (Section IV.E.) are due

(a) upon execution of a contract with MassHealth;

(b) upon renewal of the contract with MassHealth; and

(c) upon MassHealth's written request.

Please attach an additional page or pages if necessary.

II. Definitions for Sections IV. B-D

Definitions for the terms that are used in this form are provided here for your convenience. The source of these definitions is 42 CFR § 455.101.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs, as defined by 42 CFR §455.101.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes (a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII); (b) any Medicare intermediary or carrier; and (c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that (a) has an ownership interest totaling five percent or more in a disclosing entity; (b) has an indirect ownership interest equal to five percent or more in a disclosing entity; (c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity; (d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity; (e) is an officer or director of a disclosing entity that is organized as a corporation; or (f) is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

III. Determination of Ownership or Control Percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. The source of these definitions is 42 CFR § 455.102.

A. Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation, which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

B. Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

IV. Disclosures

A. Identification Information

All applicants, bidders, disclosing entities, fiscal agents, and providers, including MCEs, must complete this section.

Name:_____

_____

_____

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

_____

Provider ID/service location (PID/SL) for existing MassHealth providers: _____

_____

_____

Contact person: _____

Title: _____

Phone no.: _____

B. Ownership and Control

All applicants, bidders, disclosing entities, fiscal agents, and providers, including MCEs, must complete this section, unless otherwise directed by MassHealth.

(1) List the name and address of any person (individual or legal entity) with an ownership or control interest in the entity providing these disclosures, or with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more. Provide the date of birth and SSN (for individuals identified), or other TIN (for legal entities identified), and complete the additional requested information. Attach a separate sheet if additional space is needed. If there is no person or entity in this category, please respond "None."

(a) Name: _____

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

SSN or TIN: _____

Date of birth (if an individual): _____

The individual or legal entity identified above has an ownership or control interest in which entity(ies):

- The entity providing these disclosures? ☐ Yes ☐ No
- A subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more? ☐ Yes ☐ No

► Name and address of the subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

_____

► SSN or TIN of the subcontractor:

_____

_____

(b) Name: _____

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

SSN or TIN: _____

Date of birth (if an individual): _____

The individual or legal entity identified above has an ownership or control interest in which entity(ies):

- The entity providing these disclosures? ☐ Yes ☐ No
- A subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more? ☐ Yes ☐ No

► Name and address of the subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

_____

► SSN or TIN of the subcontractor:

_____

_____

(2) Identify any individuals or legal entities named in question 1 as having an ownership or control interest, who are related to each other as spouse, parent, child, or sibling; and identify the particular relationship. If there are no such relationships, please respond "None."

_____

_____

_____

_____

(3) Identify any individuals or legal entities listed in question 1 as having an ownership or control interest, who also have an ownership or control interest in any other disclosing entity (or fiscal agent or MCE), and provide the name of each such other disclosing entity. If there are no individuals or legal entities with such interest, please respond "None." Attach a separate sheet if additional space is needed.

(a) Name: _____

Other entity name: _____

Other entity address: _____

(b) Name: _____

Other entity name: _____

Other entity address: _____

(4) Identify and provide the following information for each managing employee. If there are no managing employees, please respond "None." Attach a separate sheet if additional space is needed.

(a) Managing employee: _____

Address: _____

SSN: _____

Date of birth: _____

(b) Managing employee: _____

Address: _____

SSN: _____

Date of birth: _____

(c) Managing employee: _____

Address: _____

_____

_____

SSN: _____

Date of birth: _____

C. Business Transactions

Complete this section only if MassHealth directs you to do so. (Applicants and fiscal agents do not need to complete this section.)

(1) Identify the ownership of any subcontractor with whom the provider, including an MCE, has had business transactions totaling more than $25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent or more. If there are no such business transactions to report, please respond "None." Attach a separate sheet if additional space is needed.

(a) Subcontractor: _____

Address: _____

_____

SSN or TIN: _____

(i) Name of owner: _____

Address: _____

_____

(ii) Name of owner: _____

Address: _____

_____

(b) Subcontractor: _____

Address: _____

_____

SSN or TIN: _____

(i) Name of owner: _____

Address: _____

_____

(ii) Name of owner: _____

Address: _____

_____

(2) Identify any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five-year period before the date of this request. If there are no significant business transactions to report, please respond "None." Attach a separate sheet if additional space is needed.

_____

_____

_____

D. Criminal Convictions

Applicants, bidders, and providers, including MCEs, must complete this section, unless otherwise directed by MassHealth.

Provide the requested information in this section for any person who

(1) (a) has an ownership or control interest in the disclosing applicant, bidder, MCE or provider, or

(b) is an agent or managing employee of the disclosing applicant, bidder, MCE or provider; and

(2) has also been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs.

If there are no persons with such interest, please respond "None." Attach a separate sheet if more space is needed.

Person 1

Name: _____

Address: _____

Relationship: ☐ person with an ownership or control interest
☐ agent
☐ managing employee

Conviction Information:

Crime(s): _____

Date of conviction: _____

Person 2

Name: _____

Address: _____

Relationship: ☐ person with an ownership or control interest
☐ agent
☐ managing employee

Conviction Information:

Crime(s): _____

Date of conviction: _____

E. Relationships to Excluded, Penalized, or Convicted Persons in accordance with 42 CFR §1002.3

All bidders, applicants, providers, including MCEs, must complete this section, unless otherwise directed by MassHealth.

(1) For purposes of section E only, the following terms are as defined in 42 CFR §1001.1001:

Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

Immediate family member means, a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)

Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Ownership interest means an interest in:

(a) The capital, the stock or the profits of the entity, or

(b) Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

(2) (a) Please identify, and provide the requested information in this section regarding any person who:

(i) has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;

(ii) has had civil money penalties or assessments imposed under section 1128A of the Social Security Act; or

(iii) has been excluded from participation in Medicare or any of the state health care programs, **and**

(b) who also has one or more of the following relationships to the disclosing bidder, applicant, MCE, or other provider:

(i) has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the entity;

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity;

(iii) is an officer or director of the entity, if the entity is organized as a corporation;

(iv) is partner in the entity, if the entity is organized as a partnership;

(v) is an agent of the entity;

(vi) is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof; or

(vii) was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

If there are no persons with such interest, please respond "None." Attach a separate sheet if more space is needed.

Person 1

Name: _____

Address: _____

Relationship: _____
☐ Current ☐ Former

☐ Conviction Information:

Crime(s): _____

Date of conviction: _____

☐ Penalty or Assessment Information:

Reason(s): _____

Date penalty or assessment imposed: _____

Exclusion Information (Medicare):

Reason(s): _____

Date of exclusion: _____

☐ Exclusion Information (state health care program):

State(s): _____

Reason(s): _____

Date of exclusion: _____

Person 2

Name: _____

Address: _____

Relationship: _____
☐ Current ☐ Former

☐ Conviction Information:

Crime(s): _____

Date of conviction: _____

☐ Penalty or Assessment Information:

Reason(s): _____

Date penalty or assessment imposed: _____

Exclusion Information (Medicare):

Reason(s): _____

Date of exclusion: _____

☐ Exclusion Information (state health care program):

State(s): _____

Reason(s): _____

Date of exclusion: _____

F. Provider/Fiscal Agent/MCE/Applicant, Bidder Attestation, Signature, and Date

All providers, disclosing entities, fiscal agents, MCEs, applicants, and bidders must complete this section.

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under the pains and penalties of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's/disclosing entity's/fiscal agent's/MCE's/applicant's/bidder's signature (signature and date stamps, or the signature of anyone other than the provider/fiscal agent, applicant, bidder, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.):

Signature: _____

Date: _____

Printed name: _____

Title: _____

Appendix H

Service Area

Bristol County

Essex County

Franklin County

Hampden County

Hampshire County

Middlesex County

Norfolk County

Plymouth County

Suffolk County

Worcester County

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth Data Warehouse

Paid Encounter Data Set Request (Expanded Format)

Version 4.7

December 6, 2017

Revision History

Date	Description	Author
12/06/2017	1.1 Data requirements segment Added new bullets that are marked as "*Bullet introduced in this version of the document*" 2.0 Data Elements Clarifications segment Provider IDs: added new lines marked as "*Line introduced in this version of the document".* **"Org. Code", field # 1 in all the files, is set to accept 3 N values. Encounter data set Provider Data Set MCE Internal Provider Type Data Set Elements with Record Layout Provider Specialty Data Set Elements Additional Reference Data Set Elements Member File Layout Member Enrollment File Layout Care Management Provider File Layout 3.1 Provider Data Set with Record Layout To "Reject the file if:" Added line: "c. Provider ID, or Provider ID Type, or Provider ID Location Code are missing" **Added:** • New segment "Potential Duplicate Claims" • Table N – Submission Clarification Code **Changes to the fields:** Encounter Field # 49: PCC Internal Provider ID (PCC Provider ID removed) Field # 92: PCC Internal Provider ID Type (PCC Provider ID Type removed) Field # 228: PCC Provider ID Address Location Code	Alla Kamenetsky
11/16/2017	Field #1 in all the files : "MCE PIDSL" renamed to " Org. Code" Description – "Unique ID assigned by MH DW to each submitting organization." The length of the field is changed from 10 to 3 Data Type of the values in the field changes from "C" to "N" "ACI PIDSL" in all the files has been renamed to "Entity PIDSL", Description "ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims" The length and data type remain the same – 10/C Encounter file: Field #61: Gross Payment Amount - added missing length of the field (9) and datatype (SN) Field #73: EPSDT Indicator - corrected data type to "N"	Alla Kamenetsky

Date	Description	Author
	Provider File: Field #16: Provider Type – corrected datatype to "N"	
11/09/2017	Few typos correction	Alla Kamenetsky
10/10/2017	**Added:** **Provider Data Set file** Field#40 : Provider Bundle ID Field#41: Provider ID Primary Address Location Indicator **2.0 Data Element Clarifications** ***Provider ID submission in Encounter and Provider Files*** segment with an example to illustrate how Provider IDs in claims file should correlate with the values in provider file **To the list of required fields in Provider file** 17. Provider ID Address Location Code (Field#36) 18. Provider Bundle ID (Field #40) **Changed:** All Provider ID Address Location Code fields : Length of the field = 5; Data Type = C Narrations In segment "***3.1 Provider Data Set with Record Layout***"	Alla Kamenetsky
09/20/2017	**Add to the list of changes:** Field#37: NDC Number – now will be required on Hospital and Professional claims in addition to the Pharmacy ones. Field#38: Metric Quantity - now will be required on Hospital and Professional claims in addition to the Pharmacy ones. **Removed ACO PIDSL field from :** • Internal Provider Type Data Set table • Provider Specialty Data Set Elements table • Member File Layout	Alla Kamenetsky
08/14/2017	**Secure FTP Server -** changes to the server related information in the section **Data Requirements** section – mentioning of ACO program implementation **Data Set Elements** tables are enhanced with Record Layout information. **Obsolete:** ○ Encounter Record Layout section ○ Provider Record Layout section **Encounter Data Set** *Changes to the existing fields* Field#1: MCE PIDSL (former Claim Payer) Field#3: ACO PIDSL (Former "Plan Identifier") Field#7: - Pricing Indicator (former "Filler") - the length changed from 9 to 20	Alla Kamenetsky

Date	Description	Author

Field#13: Submission Clarification Code "(former "Filler")
Field#32: Gender Code, added value of
"O" for "Other"
Field #33: Type of Bill (former "Place of Service Type")
Field#71: Added values of "7 = ACO-A",
"8 = ACO-B" and "9= ACO-C"
Field#195: ACO Categories, added value 'ACO' for ACO Service Category Type
Introducing new fields

Field #204: Value Code
Field #205: Value Amount
Field # 206 - 221: Surgical Procedure Codes 10-25
Field#222: Attending Prov. ID Address Location Code
Field#223: Billing Provider ID Address Location Code
Field#224: Prescribing Prov. ID Address Location Code
Field#225: PCP Provider ID Address Location Code
Field#226: Referring Provider ID Address Location Code
Field#227: Servicing Provider ID Address Location Code Address Location Code
Field#228: PCC Internal Provider ID
Field#229: PCC Internal Provider ID_Type
Field#230: PCC Provider ID Address Location Code

Provider Data Set Elements related tables and Additional Reference Data Set Elements:

Changed and added fields
Field #1 "Claim Payer" is replaced with "MCE PIDSL"
Added field "ACO PIDSL" at the end of the files

Provider Data Set file

Field #	***Field Name***	***Former Field Name***
1	MCE PIDSL	Claim Payer
22	PCC Provider ID	IPA/PMG ID
31	PCC Provider ID Type	IPA/PMG ID_Type
35	ACO PIDSL	
36	Provider ID Address Location Code	
37	PCC ID Address Location Code	
38	Provider Network ID TYPE	
39	Provider Network ID Address Location Code	

Internal Provider Type Data Set

Field#	***Field Name NEW***	***Former Field Name***
1	MCE PIDSL	Claim Payer
6	ACO PIDSL	
7	Provider ID Address Location Code	

Provider Specialty Data Set Elements

Field#	***Field Name NEW***	***Former Field Name***
1	MCE PIDSL	Claim Payer

<table>
<tr><th>Date</th><th>Description</th><th>Author</th></tr>
<tr><td></td><td>
<table>
<tr><td>7</td><td>ACO PIDSL</td><td></td></tr>
<tr><td>8</td><td>Provider ID Address Location Code</td><td></td></tr>
</table>
<u>Member Enrollment File</u>
<table>
<tr><th>Field #</th><th>Field Name</th><th>Former Field Name</th></tr>
<tr><td>1</td><td>MCE PIDSL</td><td>Claim Payer</td></tr>
<tr><td>12</td><td>PCC Provider ID Address Location Code</td><td></td></tr>
<tr><td>13</td><td>PCC Practice ID Address Location Code</td><td></td></tr>
<tr><td>14</td><td>ACO PIDSL</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>06/06/2017</td><td>
III. Error Handling
<table>
<tr><td>New error codes added72*</td><td>Denial Code not in Denied Claims file - Claim Number/Suffix in Denied Claims Reason Code file not in Denied Claims file</td></tr>
<tr><td>73*</td><td>Claim Number/Suffix in Denied Claims file not in Denied Claims Reason Code file</td></tr>
<tr><td>74</td><td>Correction to a claim that is not in MH DW</td></tr>
</table>
* Specific for denied claims only
</td><td>Alla Kamenetsky</td></tr>
<tr><td>01/25/2017</td><td>
In Service Data segment

a) Field # 7 renamed to “Place Holder for Pricing Indicator” (Former “Filler”)

b) Field # 13 renamed to “Submission Clarification Code”– (Former “Filler”)

c) Field # 31 “Revenue Code” less than 4 digit codes should be entered with leading zeros.

d) “Place of Service” and “Type of Bill” values are submitted in separate fields now:
#32 “Place Of Service”;
#33 “Type of Bill” – (Former “Place of Service Type”)

e) Field #33 “Type of Bill” should be sent in 3 digit format including Frequency as 3rd digit.

f) Field # 35 renamed to “FILLER” (Former “Type of Service”, which is no longer required).

g) Added Value “Other” to Field #9 “”Recipient Gender” in Encounter Data Set Elements;
Field # 9 “Member Gender” in Member File Layout ”
</td><td>Alla Kamenetsky</td></tr>
<tr><td>09/09/2016</td><td>
<u>I. In Data Elements Clarifications (section 2.0):</u>
1. Introduced new Inpatient Claim logic for the claims with DOS on or after October 1, 2016.

<u>II. In Table I-B “Service Category (Using the SCO reporting groups)”</u>
Replaced “100” series values with
‘300’ series values.
New Service Categories are in Table I-B1;
Old Service Categories are in Table I-B2.
</td><td>Alla Kamenetsky</td></tr>
</table>

Date	Description	Author
01/11/2016	***I. In Additional Reference Data Set Elements (Section 3.4):*** Table *Services Data Set Elements* Added 5 new fields – MBHP specific. ***Additional Reference Data Layout (Section 4.5)*** Table *Services Data Set Layout* Added 5 new fields – MBHP specific. II. Added information about new BMC SCO to the list of all SCOs throughout the document. III. Replaced ICD-9-CM with ICD throughout the document.	Alla Kamenetsky
09/29/2015	**I.** ***In Data Elements Clarifications*** **(*section 2.0):*** 1. Changed Inpatient Claim logic back to the old definition. **II**. ***In Encounter Data Set Elements (section 3.0):*** 1. Changed field #7 description back to "Filler". 2. "New Member ID" (field#76) - missing or invalid value in this field will be considered as a fatal error resulting in rejection of the record. **III.** ***In 3.1 Provider Data Set:*** 1. Edited ***File Processing*** section 2. Added a list of the fields that are 100% required to be complete with valid values on all the records. 3. Removed proposed "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). 4. Updated definition of "APCD ORG ID" (field#34) **IV**. ***In 4.0 Encounter Record Layout*** The length of "Recipient ZIP Code" (field#10) remains 5 N. **V**. ***In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks*** **Updated definitions of MassHealth Standards in**: -"Admission Date'' (field#15) -"Discharge Date''(field#16) -''Type of Admission" (field#24) -"Source of Admission" (field#25) -"Place of Service" (field#32) -"Patient Discharge Status" (field#34) -"Days Supply" (field#39) -"Refill Indicator" (field#40) -"Dispense as Written Indicator" (field#41) -"Admitting Diagnosis" (field#85) -"ICD Version Qualifier" (field#193)	

Date	Description	Author
08/31/2015	***I. In Data Elements Clarifications (section 2.0):*** 1. Added Capitation Payments clarification. **2**. Updated Inpatient Claim clarification ***II. In Encounter Data Set Elements (section 3.0):*** **1**. "Claim Category" (field #2) removed option "7 = Other (should be rarely used)" 1 **2.** Changed definition of "Plan Identifier" (field #4) o. **3**. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator" **6**.**Updated definitions of** : "Admission Date"(field#15) "Discharge Date" (field#16) "Type of Admission" (field#24) "Source of Admission"(field#25) ''Procedure Code'' (field #26), ''Procedure Code Indicator" (field #30)'' "Revenue Code" (field# 31) "Place of Service" (field # 32) Place of Service Type" (field#33) "Patient Discharge Status" (field#34) "Quantity" (field#36) "NDC Number" (field# 37) "Metric Quantity" (field #38) "Dispense As Written Indicator'' (field#41) "DRG" (field#72) "Prescribing Prov. ID" (field#81) "DRG Severity of Illness Level" (field#122) "DRG Risk of Mortality Level" (field#123) **III.** I***n 3.2 Provider Data Set:*** 1, Added "File Processing" paragraph. 2. Updated definitions of: "Provider ID" (field#2) "Medicaid Number" (field#5) "Provider Last Name" (field#6) "Provider Fist Name" (field#7) "Provider Type" (field16) "Social Security Number" (field#28) "Tax ID Number" (field#30) Added two new fields: "APCD ORG ID" (field#34) and "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). ***IV. In 4.0 Encounter Record Layout*** 1. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator". 2. Increased fields length: "Recipient ZIP Code" (field#10) from 5 N to 9 N; "Quantity" (field#36) from 5 N to 9 N; "Metric Quantity" (field#38) from 5N to 9 N ***V. In 4.1 Provider Record Layout***	Rima Kayyali Alla Kamenetsky

Date	Description	Author
	1. Increased fields length: “Provider Last Name” (Field # 6) from 30 C to 200 C “Provider Fist Name” (Field#7) from 30 C t0 100 C 2. Added two new fields: “APCD ORG ID” (field 34) – 6 C “Health Policy Commission registered Provider Organization ID (RPO)” (field#35) – 30 C ***In Table B “*Source of Admission (UB)”** Added values A-F ***In Table G*** “***Servicing Provider type”*** removed option “-4 -Incomplete/No information”. **VI**. ***In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks*** 1.Replaced “Filler” with “Header / Detail Claim Line Indicator” (field#7) 2, Updated definitions of MassHealth Standards in: “Admission Date’’ (field#15) ‘\Discharge Date’’(field#16) ‘‘From Service Date’’(field#17) ‘’To Service Date” (field#18) ‘’Primary Diagnosis” (field#19) ‘’Type of Admission” (field24) “Source of Admission” (field25) “Procedure Code” (field26) “Revenue Code” (field 31) “Place of Service” (field 32) “Place of Service Type” (field 33) “Patient Discharge Status” (field 34) “Quantity” (field#36) “Servicing Provider ID” (field#50) ‘‘Billing Provider ID’’ (field#58) “DRG” (field#72) “New Member ID” (field#76) “Prescribing Prov. ID” (field#81) “Date Script Written” (field#82) “Admitting Diagnosis” (field#85) “Frequency” (field#91) “ICD Version Qualifier” (field#193)	
04/15/2015	1. Updated a name of Monthly Financial Report in the examples with the current dates on pgs. 62-63.	Alla Kamenetsky
10/30/2014	1. Added reference to One Care-ICO 2. Changed Instructions on Monthly Financial Report. pg62-63 3.Changed format of Provider_IDs paragraph on pg.10 4. Changed length value in field #86 to 9. pg.47 5. Changed length value in field #12 to 10. pg.55. 6. Changed format of zip file name. pgs. 59-60 7. Added Table I-C “Service Category (Using the One Care - ICO reporting groups)”	Alla Kamenetsky

Date	Description	Author
	pg.92	
4/23/2014	1. Added clarification in section 2.0 (Diagnosis Codes). 2. Added clarification in section 8.0 on validation of ICD Version Qualifier (Field # 193), ICD Diagnosis and ICD Procedure codes	Rima Kayyali
12/31/2013	Deleted ICO Reference	Rima Kayyali
12/17/2013	Added value "5" for CarePlus population to field Group Number (field # 71)	Rima Kayyali
11/26/2013	Updated Appendix C (Section 9.3) for Member Enrollment File Specifications	Rima Kayyali
8/13/2013	Added Appendix C in Section 9.3 for Member Enrollment File Specifications	Rima Kayyali
4/26/2013	1. Changed Encounter Data files submission requirement from fixed-length files to Pipe-delimited text files (delimiter=|) - Section 6.0 2. Modified Table I – B (SCO Service Category) – Section 7.0 3. Added an appendix for Provider Data File Guidelines – Section 9.0 4. Modified "Inpatient Claim" Clarification – Section 2.0 5. Added "Administrative Fees" Clarification – Section 2.0 6. Added a value of '0' to "Primary Care Eligibility Indicator" field # 33 in Provider Data set – Section 3.1 7. Added a clarifying note to "Rate Increase Indicator" Field # 200 – Section 3.0 8. Clarified that the monthly financial report should include both MH and Comm Care Populations (Section 1.1), and that it should be submitted subsequent to submission of Manual Override (Section 6.0)	Rima Kayyali
2/21/2013	Modified Provider Data Record Layout, MCE Internal Provider Type and Metadata	Rima Kayyali
1/17/2013	Modified based on feedback received from MCE in 1/17/2013 meeting	Rima Kayyali
1/15/2013	Added Flags for "ACA 1202 Rate Increase" eligibility	Rima Kayyali
11/05/2012	Final Updates	Rima Kayyali
8/16/2012	Updates Based on Meeting Discussions	Rima Kayyali
6/6/2012	Updated Encounter Data Set Elements with additional fields. Updated Tables.	Rima Kayyali
11/22/2010	Added more detailed descriptions	Kelly Zeeh

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Acronyms

ACO	Accountable Care Organization
DW	Data Warehouse
EOHHS	Executive Office of Health and Human Services
MBHP	Mass Behavioral Health Plan
MCE	Managed Care Entity (MCO, SCO, One Care, and MBHP collectively)
MCO	Managed Care Organization
MH	MassHealth
PCC	Primary Care Center
PIDSL	Provider ID Service Location
SCO	Senior Care Organization

1.0 Introduction

MassHealth Data Warehouse was required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in managed care programs. EHS is using the database for a number of different projects including Centers for Medicare and Medicaid Services (CMS, formerly HCFA) reporting, program evaluation, and rate development. It is critical that each Managed Care Entity (MCO, MBHP, SCO, and One Care) provides EHS DW with records accurately reflecting all encounters provided to Medicaid recipients enrolled in MCEs' managed care program. Only with complete and accurate encounter data MassHealth is able to assess the effectiveness of the managed care program.

With the implementation of the ACO project, all MCEs are required to submit extended encounter information on paid claims and related data. Encounters for both, MCO and ACO should be submitted in the same file.

For denied claims submissions, please see denied claims specifications document.

All the plans, including SCO and One Care plans should follow the new file format in their submissions.

MassHealth expects the MCEs to provide new, replacement, and void claims in each submission. MassHealth processes the data and returns rejected claims to the MCEs with the appropriate error codes. MCEs are expected to correct the offending claims and send them in a correction file within a week. **The submission-rejection-resubmission cycle has to be completed within a month of submission**. The number of rejected claims must be below a MassHealth defined threshold.
If you cannot submit data in this fashion, or if you have any questions about any of these documents, please contact Alla Kamenetsky at *Alla.Kamenetsky@state.ma.us*

1.1 Data Requirements

- The data referred to in this document are encounter data - records of health care services performed for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a unique service or procedure performed for a recipient. Multiple encounters can occur during a single visit to a provider, and each encounter should have a separate encounter record.

  - Send all fully adjudicated paid claims. All claims should reflect the final status of the claim on the date it is pulled.

  - Submit one encounter record for each service performed (i.e., if a claim consisted of five services, each service should have a separate encounter record).

  - Data should conform to the Record Layout specified later in this document. Any deviations from this format must be approved by EHS.

  - **Each row in a submitted file should have a unique Claim Number + Suffix combination.**

  - Only Paid claim lines should be submitted.

  - A feed should consist of new (original) claims, amendments, replacements and voids.
    The replacements and voids should have a former claim number and former suffix to associate them with the claim+suffix they are voiding or replacing.

  - The association of the adjustments and voids to the ACO claims will be based on the date of service, so there will not be a situation where the original claim is associated with an ACO and the adjustment - with an MCO and vice versa.

- While processing the submission, MassHealth scans the files for the errors and returns error reports in the format of the input file with extra two columns to indicate an error code and the field with the error. MCEs should correct the errors and resubmit the records within a week from the date the file was loaded.

  - MassHealth is in the process of identifying potentially duplicate claims submitted as originals (Record Type = "O"). All the MCEs will get a report of the associated duplicates tied to the latest submission right after the file is loaded. For more details about the file format refer to the section "Potential Duplicate Claims". (*Bullet introduced in this version of the document*)

  - Potential duplicate encounters are currently accepted by MassHealth. The expectation is that the MCEs will review the files of the potential duplicates and take the necessary actions to fix the issue. The voids of the duplicated claims should be included in the regular submission file. (*Bullet introduced in this version of the document*)

  - Monthly Financial reports to be validated against the Encounter Data in EHS DW. The Financial - reports should follow the same logic as the quarterly financial reports (e.g., 4B reports for MCOs, financial reports for SCOs and One Care). Reported cost must be associated with dates of service during the reported month for claims paid through the end of the following month. For example, financial report for the month of March will be submitted in May for the claims with dates of service from March 1 through March 31and paid through April 30.

- **The MCEs that provide services to MassHealth and Commonwealth Care members should include services for both populations in the financial report.**

Please see "Monthly Financial Report" under section 6.0 "Media Requirements" for specific instructions on report layout and submission.

1.2 How to Use this Document

This *Encounter Data Set Request* is intended as a reference document. Its purpose is to identify the data elements that MassHealth needs to load into encounter database. The goal of this document is to clarify the standard record layout, format, and values that MassHealth will accept.

Data Element Clarifications

In 2.0 "Data Set Clarification" section provides clarifications and expectations on data elements like DRG, Diagnosis Codes, Procedure Codes, and Provider IDs.

Data Elements

The information contained in the Data Elements sections defines each of the fields included in the record layout. When appropriate, a list of valid values is included there. Nationally recognized coding schemes have been used whenever they exist.

Encounter Record Layout

Section 4.0 "Encounter Record Layout" specifies encounter file layout. All the MCEs must use that format when compiling the Encounter Data file that might contain all or any Claim Category (facility, professional, dental, etc.). MassHealth requests that the encounter data file is provided in a pipe-delimited text file with each service on a separate line.
Contact MassHealth if you need further clarification.

Media Requirements and Data Formats

Section 6.0 "Media Requirements and Data Formats" contains complete information about all the files that should be submitted to EHS DW. MCEs submit their data to MassHealth through a secure FTP server. Each MCE has a home directory on this server and is given an ID with public key/private key-based login. Please also note the security requirements for Internet transmissions noted in the Media Requirements section.

Standard Data Values

Section 7.0 "Standard Data Values" contains tables referenced in the specific fields of the Data Elements section (Tables A through H).

Data Quality Checks

This section within 8.0 "Quantity and Quality Edits, Reasonability and Validity Checks" provides the validity and quality criteria that encounter data are expected to meet.

2.0 Data Element Clarifications

MassHealth has identified several data elements that require further clarification with respect to the expectations for those elements. The information in this section details MassHealth's expectations for Recipient Identifiers, Provider IDs, DRG, Diagnosis Codes (primary through fifth), and Procedure Codes.

Member Ids
Encounter data records must include MassHealth member IDs that are "active" as of the time of data submission.

Provider Ids
MassHealth is asking plans to provide an identifier that is unique to the plan. The acceptable ID types are:

ID Type	ID Description	Comments
1	NPI	Accepted for any provider including Referring and Prescribing Provider IDs. Note: MassHealth expects MCEs to submit MCE Internal ID in Provider IDs and use NPI as a Provider ID only when necessary and when an internal ID is not available. When NPI is used in Provider ID fields, provider file must have it entered in Field #2 (Provider ID) and in field #26 (NPI). Field #26 (NPI) must also be populated for all other Provider ID types except when it's not available, like in the case of atypical providers.
6	MCE Internal ID	Accepted for any provider
8	DEA Number	Should be used with pharmacy claims only
9	NABP Number	Should be used with pharmacy claims only

- All the provider attributes should be filled out in the provider file as much as possible.
- The Provider ID, Provider ID Type, and Provider ID Location Code should be 100 % present on all the provider records. (*Line introduced in this version of the document*)
- At least 80% of the records should have NPI numbers included.
- At least 80% of the records should have Provider Type entered. (*Line introduced in this version of the document*)
- All the provider records in provider file, which are part of the PCC enrollment with MCE, need to have PCC details on the same line. *(Line introduced in this version of the document)*

NPI
The Centers for Medicare & Medicaid Services (CMS) require all Medicare and Medicaid providers and suppliers of medical services that qualify for a National Provider Identifier (NPI) to include NPI on all claims. Type 1 NPI is for Health care providers who are individuals, including physicians, psychiatrists and all sole proprietors. Type 2 NPI is for Health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

MCEs should submit the individual NPI (Type1) for Servicing/Rendering, Referring, Prescribing, and Primary Care Providers. MCEs should submit individual (Type 1) or group (Type 2) NPI for billing providers and PCC. MassHealth will reject claims that point to a servicing/rendering, billing and referring provider with missing NPI in the Provider File with the exception of "atypical" providers.

DRG

The DRG field (field #72) is a field requested by CMS. Not all plans collect DRGs so MassHealth has developed a preferred course of action:

1. A plan that collects DRGs- should provide DRG values in data submissions.
2. A plan that does not collect DRGs, should ensure that primary, secondary, and tertiary diagnosis values are as complete and accurate as possible, so that MassHealth may use a DRG grouper if necessary. Accurate procedure codes are also required for DRG assignment.
3. In the future, MassHealth may request that all plans provide DRGs.
4. MassHealth requests from MCEs that report DRGs to also report in DRG related fields: DRG Type, DRG Version, Severity of Illness level, and Risk of Mortality.

Diagnosis Codes
Requirements for validity and completeness are detailed in the ICD clinical guide that is published by the American Medical Association. Current validating process at MH DW requires that diagnosis codes contain the required number of digits outlined in the ICD code books.

At least one diagnosis code (in Primary Diagnosis field #19) is required for all provider type encounters as specified in section 8.0.
The values in all other Diagnosis fields listed in Data Elements section should be submitted as much as possible.

Procedure Code
Many plans accept and use non-standard codes such as State specific and MCE specific codes. Current validating process at EHS DW looks for standard codes only - CPT, HCPCS, and ADA.

HIPPAA regulations require that only standard HCPCS Level I (CPT) and II be used for reporting and data exchange.
The only field containing procedure codes is the Procedure Code field (field #26).

Capitation Payments
Capitation payment arrangement refers to a periodic payment per member, paid in advance to health care providers for the delivery of covered services to each enrolled member assigned to them. The same amount is paid for each period regardless of whether the member receives the services during that period or not.
Note: Capitation payment is not "Bundled" payment, which is usually paid for Episodes of care or other bundled services.

Dollar Amounts
MassHealth wants to ensure that the dollar amounts on the individual lines of the claim represent the actual or computed amounts associated with each encounter. Therefore, whenever dollar amounts are not included at the detail level, and the summary-level line is not available, the MCE should add an extra detail line with a Record Indicator of 0 and report all summary-level amounts/quantities on that line. If the summary-level line is already available in the MCE's source system and is not artificially created, then it should have a Record Indicator 6 (Bundled Summary-Level line) **unless** other Record Indicator values apply (like, for example, 5 for DRG).
All detail lines with 0 dollar amounts (that are **not** artificially created and are **not** summary-level lines) should have any value **other than 0 or 6** placed in Record Indicator field. In such case, MCE decides on the value based on the definition of the Record Indicator in the table below.

For the claims covered by the capitation payments, MCEs must report either FFS equivalent amounts or amounts reported by the provider/vendor on their claims and use Record Indicator values 2 or 3 to indicate the type of payment arrangement.

Record Indicator Table:

Record Indicator	Dollar Amount Split
0: Artificial Line	Dollar amounts / quantities represent numbers that are available only at a summary level.
1: Fee-For-Service	Dollar amounts should be available at the detail line level in the source system.
2: Encounter Record with FFS equivalent	Dollar amounts should be available at the detail line level in the source system for a service provided under a capitation arrangement

Record Indicator Table (cont'd):

Record Indicator	Dollar Amount Split
3: Encounter Record w/out FFS equivalent	Dollar amount, if any, as reported by the provider or vendor to the MCE for a service provided under a capitation arrangement
4: Per Diem Payment	Total dollar amount for the entire stay. This is not the per-diem rate but the per-diem rate multiplied by the Quantity [numbers of days of inpatient admission. See Quantity]. If the amount applies to all lines on the claim, the claim must bring in a record with indicator = 0.
5: DRG Payment	Total dollar amount for the entire stay. If the amount applies to all lines on the claim, the claim must bring in a record with indicator = 0.
6: Bundled Summary-Level Line	Total dollar amount for a bundled summary-level claim line where the dollar amounts represent numbers that are available only at a summary line level in the source system and is not artificially created. A record with indicator = 6 for a **summary-level line of a bundled claim is used when none of the above payment arrangements apply**
7: Bundled detail line with 0 dollar amount	A bundled detail claim line where the dollar amounts are 0 or not available at the detail level. A record with indicator = 7 is used for a **detail-level line of a bundled claim when none of the above payment arrangements apply**

Below are few examples of possible scenarios for Record Indictor values:

Example 1 - Artificial Line 0 and Detail Lines with Record Indicator 4:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
44444444444	1	4 - Per Diem Payment	0
44444444444	2	4 - Per Diem Payment	0
44444444444	3	4 - Per Diem Payment	0
44444444444	4	4 - Per Diem Payment	0
44444444444	5	0 - Artificial Line: dollar amounts available at summary level only	260

Example 2 - Artificial Line 0 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
55555555555	1	7 - Bundled detail line with 0 dollar amount	0
55555555555	2	7 - Bundled detail line with 0 dollar amount	0
55555555555	3	0 - Artificial Line: dollar amounts available at summary level only	100

Example 3 – Bundled Summary Line 6 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
66666666666	1	7 - Bundled detail line with 0 dollar amount	0
66666666666	2	7 - Bundled detail line with 0 dollar amount	0
66666666666	3	6 - Bundled Summary-Level Line	500

Example 4 – Bundled Summary Line 6 and Detail Lines with Record Indicator 1:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
22222222222	1	1 - Fee-For-Service	0
22222222222	2	1 - Fee-For-Service	0
22222222222	3	6 - Bundled Summary-Level Line	500

Claim Number & Suffix
Every Original / Void or Replacement claim submitted to MassHealth should have a new claim number + suffix combination. There can be no duplicate claim number + claim suffix in one feed

Former Claim Number & Suffix
In order to void or replace old transactions, MassHealth requires for all the MCEs to add former claim number and former claim suffix to the claim lines of record type 'R', 'V'. The objective is to get a snapshot of the claims at the end of each period after all debit or credit transactions have been applied to them.

Examples:

Adjustments:

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Payment Amount
XXX	11111111111	4	1	O			10
XXX	33333333333	4	1	R	11111111111	4	20
XXX	88888888888	4	1	R	33333333333	4	25

Voids:

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Payment Amount
XXX	66666666666	1	1	O			15
XXX	77777777777	2	1	V	66666666666	1	10
XXX	99999999999	1	1	O			30

Record Creation Date
This is the date on which the claim was created in the MCE's database. If a replacement record represents the final result of multiple adjustments to a claim between submissions, Record Creation Date is the date of the last adjustment to that claim. For encounter records where Record Indicator value is 2 or 3, Record Creation Date should be the same as the Paid Date.

Inpatient Claim

Old, pre-November 2016, DW Logic
MassHealth applies a modified logic on encounter data to identify "Inpatient" claims. This new logic is an internal change that does not affect the encounter data submission process and only applies to the claims with "**From Service Date**" (field# 17) on or after October 1, 2016.

New DW Logic
Claims with Claim category = 1 (Facility except LTC) and **Type of Bill** values **11x and 41x** are defined as "Inpatient". All other claims with Claim category = 1 are defined as "Outpatient".

LTC Claims
Claims with claim category = 6 (Long Term Care - Nursing Home, Chronic Care & Rehab) are defined as "**LTC**". MCEs should ***continue*** sending all "Long Term Care" claims with Claim Category='6'.

Administrative Fees

Administrative Fees such as PBM fees should not be reported in the encounter data as part of the "Net Payment Amount". MCEs should inform EOHHS of any arrangement where these fees are included in their claims processing, and should work with their PBM or other agencies to separate out the administrative fees from the encounter cost component in their claim processing**.**

Bundle Indicator, Claim Number & Suffix

The Bundle indicator is a Y/N field to indicate that the claim line is part of a bundle. This indicator should always be 'Y' for **all** bundled claims (see example 1 and 2). The Bundle Claim Number and Suffix refer to the claim number and the claim suffix of the claim line with the bundled payment. The examples below illustrate how these two fields should be populated. Example 1 illustrates a scenario with one bundle within a claim, Example 2 illustrates a scenario with multiple bundles within a claim, and Example 3 illustrates a scenario with one bundle across multiple claims.

The assumption is that when a bundled claim line gets adjusted, all bundled claim lines for that claim would be adjusted as well. Please see Examples 4 and 5 below for scenarios where there is an adjustment of a bundled claim. MCE should leave the Bundle claim number and suffix blank when this assumption is inaccurate and when they do not have this information. However, these two fields are expected when MCE have this information in their system. Bundle Indicator should be provided on all bundled claims with no exception.

Example 1 – One Bundle per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	AAAAAAAA	1	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	2	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	3	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	4	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	5	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	6	Y	AAAAAAAA	6	120

Example 2 – Two Bundles per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	CCCCCCCC	1	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	2	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	3	Y	CCCCCCCC	3	60
XXX	CCCCCCCC	4	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	5	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	6	Y	CCCCCCCC	6	80

Example 3 One Bundle for Two Claim Numbers:

Claim Payer	Claim Number	Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	DDDDDDDD	1	NNNNNNNN	1	0
XXX	DDDDDDDD	2	NNNNNNNN	1	0
XXX	DDDDDDDD	3	NNNNNNNN	1	0
XXX	NNNNNNNN	1	NNNNNNNN	1	50

Example 4 – Adjustment/Void of Bundled Claims with Record Indicator 0:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount	Record Indicator	Procedure Code
XXX	44444444444	1	O			44444444444	4	0	4	96360
XXX	44444444444	2	O			44444444444	4	0	4	96375
XXX	44444444444	3	O			44444444444	4	0	4	96376
XXX	44444444444	4	O			44444444444	4	260	0	96366
XXX	55555555555	1	R	44444444444	1	55555555555	4	0	4	96360
XXX	55555555555	2	V	44444444444	2	55555555555	4	0	4	96375
XXX	55555555555	3	R	44444444444	3	55555555555	4	0	4	96376
XXX	55555555555	4	R	44444444444	4	55555555555	4	200	0	96366

Example 5 – Adjustment/Void of Bundled Claims with Record Indicator 6:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount	Record Indicator	Procedure Code
XXX	66666666666	1	O			66666666666	3	0	7	96375
XXX	66666666666	2	O			66666666666	3	0	7	96376
XXX	66666666666	3	O			66666666666	3	500	6	96366
XXX	77777777777	1	R	66666666666	1	77777777777	3	0	7	96375
XXX	77777777777	2	V	66666666666	2	77777777777	3	0	7	96376
XXX	77777777777	3	R	66666666666	3	77777777777	3	400	6	96366

Provider ID submission in Encounter and Provider Files

Among several new elements introduced in Version 4.6 of the current document are Provider ID Address Location Code fields.

The values in the Provider ID, Provider ID Type, and Provider ID Address Location fields entered in claims file should match the values in corresponding fields of the provider file.

Example:

Claims File

Entity PIDSL	Claim Number	Claim Suffix	Servicing Provider ID	Servicing Provider ID Type	Servicing Provider ID Address Location Code
999999999R	98765432WS	1	1234569	6	A
999999999R	23568974RV	1	1234568	6	B
999999999R	741852969K	1	1234567	6	C
999999999R	369874123L	1	1234566	6	D

Provider File

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234569	6	A	65656	Smith
999999999R	1234568	6	B	65656	Smith
999999999R	1234567	6	C	65656	Smith
999999999R	1234566	6	D	65656	Smith

3.0 Encounter Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the encounter record. It is divided into five sections:

- Demographic Data
- Service Data
- Provider Data
- Financial Data
- Medicaid Program-Specific Data

For fields which contain codified values (e.g. Patient Status), we have used values which are national standards (e.g. UB92 coding standards) whenever possible.

The value 'X' indicates that the data element is applicable under each Claim Category. The columns are labeled as:

- H – Facility (*except Long Term Care*)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

Programs with withhold amount

Some Managed Care programs include withhold risk-sharing arrangements with their providers when a portion of the approved payment amount is withheld from the provider payment amount and placed in a risk-sharing pool for later distribution. In such case, the withheld amount should be recorded in a separate field "Withhold Amount" (#69) and included in the amounts in the Eligible Charges and "Net Payment" (#68) fields.

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	X	X	X	X	X	3	N

2	Claim Category	A code indicating the category of this claim. Valid values are: 1 = Facility (*except Long Term Care*) 2 = Professional (includes transportation claims) 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care *(Nursing Home, Chronic Care & Rehab)*	X	X	X	X	X	1	C
3	Entity PIDSL	ACO PIDSL on the ACO claims or MCO PIDSL on the MCO claims or One Care Plan PIDSL on One Care claims or SCO PIDSL for SCO claims Example: 999999999A	X	X	X	X	X	10	C
4	Record Indicator	This information refers to the payment arrangement under which the rendering provider was paid. Value identifies whether the record was a fee-for-service claim, or a service provided under a capitation arrangement (encounter records). For encounter records, indicate whether or not there are Fee-For-Service (FFS) equivalents and payment amounts on the record. 0 Artificial record – Refers to a line item inserted to hold amounts / quantities available only at a summary (claim) level. 1 Claim Record – Refers to a claim paid on a Fee-For-Service (FFS) basis	X	X	X	X	X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
	Record Indicator (Continued)	2 Encounter Record with FFS equivalent - Refers to services provided under a capitation arrangement and for which a FFS equivalent is given 3 Encounter Record w/out FFS equivalent - Refers to services provided under a capitation arrangement but for which no FFS equivalent is available 4 Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5 DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis 6 Bundled Summary-Level Line – Refers to a record with a bundled summary-level amounts/quantities as available in the MCE source system. Use this value when none of the above values apply. 7 Bundled detail line with 0 dollar amount – Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply ***See discussion under <u>Dollar Amounts</u> in the Data Elements Clarification Section.***							
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. ***See discussion under <u>Claim Number/Suffix</u> in***	X	X	X	X	X	15	C

		the Data Elements Clarification Section							
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
7	Pricing Indicator	Pricing Indicator; currently it is a subject of internal discussion. MCEs will be notified when decision is made.						20	C
8	Recipient DOB	The birth date of the patient expressed as YYYYMMDD. For example, August 31, 1954 would be coded “19540831”.	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	The gender of the patient: 1 = Male 2 = Female 3 = Other	X	X	X	X	X	1	C
10	Recipient ZIP Code	The ZIP Code of the patient’s residence as of the date of service.	X	X	X	X	X	5	N
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B	X	X	X	X	X	1	N

Service Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
12	Other Insurance Code	A Yes/No flag that indicates whether or not third party liability exists. 1 = Yes; 2 = No	X	X	X	X	X	1	C
13	Submission Clarification Code	420-DK- Code indicating that the pharmacist is clarifying the submission. Values from 1 to 36 should be sent on pharmacy claims when available. The values and descriptions of the Submission Clarification Code are in Table N		X				7	N
14	Claim Type	MBHP Specific field	X	X	X	X	X	18	C
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X				
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. Cannot be prior to Admission Date.	X		X			8	D/YYYYMMDD
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. The code should be left justified, coded to the fifth digit when applicable (blank filled when less than five digits are applicable). *DO NOT include decimal points in the code.* ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X	7	C/ No decimal points (780.31 must be entered as 78031)
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points
24	Type of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table A.	X		X			1	C
25	Source of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table B	X		X			1	C

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. *Any internal coding systems used must be translated to one of the coding systems identified in field* ***#30*** *below.* Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#101 – #113) ***including the ICD-treatment procedure codes*** ***See discussion in Data Element Clarifications section.***	X	X	X		X	6	C
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X	2	C
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X	2	C
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X	2	C
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in surgical procedure code fields (Field # 103 – 111) *State defined procedure codes should be used, when coded, for services such as EPSDT procedures.* ***See discussion in the Data Element Clarifications section.***	X	X	X		X	1	N
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. *Only standard UB92 Revenue Codes values are allowed; plans may* ***not*** *use "in house" codes. Values should be sent in 4 digit format. Revenue codes less than 4 digits long should be submitted with leading zeros. For Example:* *a. Revenue code 1 should be submitted as '0001';* *b. Revenue Code 23 - as '0023;* *c. Revenue code 100 - as '0100';* *d. Revenue Code 2100 – as '2100'.*	X		X			4	C
32	Place of Service	This field hosts Place of Service (POS) that comes on the Professional claim). See Table C for CMS 1500 standard		X			X	2	C

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
33	Type Of Bill	For encounter data supporting UB claims submission the Type of Bill is submitted as a 3-digit bill type in accordance with national billing guideline. The first two digits denote the place of services and the third digits denotes the frequency. See Table D for UB Type of Bill values indicating place. ***Note*****:** for UB Type of Bill, use the 1st and 2nd positions only.) Frequency values can be found in Table K and are documented in field # ***91 as well.***	X	X	X		X	3	C
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading '0'. Examples: a. Patient Discharge Status '1' should be submitted as '01'; b. Patient Discharge Status '19' should be submitted as '19'.	X		X			2	C
35	Filler							2	C
36	Quantity	This value represents the actual quantity and should be submitted with decimal point when applicable. For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For all other procedures, the number of units performed for this procedure. For most procedures, this number should be "1". In some cases, a procedure may be repeated, in which case this number should reflect the number of times the procedure was performed. For anesthesia services, this should be the total number of minutes that make up the beginning and ending clock time of anesthesia service administered. Please make sure that the Quantity corresponds to the procedure code. For example, if the psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes), the Quantity should be "1" NOT "45" or "50". For Inpatient records, it should represent number of days of care. Values of 30, 60 or 100 are most common on drug records. Note: Length of this field has been increased to accommodate the actual quantity. Quantity=10 should be submitted as 10; Quantity=10.5 should be submitted as 10.5; Quantity=10.55 should be submitted as 10.55		X	X		X	9	SN

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, If primary drug is unknown, submit NDC Number for most expensive drug. NDC codes having less than 11 digits should be submitted with leading 0's. For Example NDC "603373932" should be submitted as "00603373932".	X	X		X		11	N
38	Metric Quantity	For prescription drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. Note: Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55	X	X		X		9	N
39	Days Supply	The number of days of drug therapy covered by this prescription.				X		3	N
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X		2	N
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2 digit format with leading zero: 00 = No DAW 01 = Physician DAW 02 = Patient DAW 03 = Pharmacist DAW 04 = Generic Not In Stock 05 = Brand Dispensed as Generic 06 = Override 07 = Brand Mandated by Law 08 = No Generic Available 09 = Other				X		2	N
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right					X	1	N
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)					X	2	C
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual I = Incisal F = Facial					X	6	C

		B = Buccal A = All 7 surfaces This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as "MOL "(three spaces following the third value).							
45	Paid Date	For encounter records, the date on which the record was processed. For services performed on a fee-for-service basis, the date on which the claim was paid. The format is YYYYMMDD.	X	X	X	X	X	8	D/YYYY MMDD
46	Service Class	MBHP Specific field	X	X	X	X	X	23	C

Provider Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section.***	X	X	X		X	15	C
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, 6 = Internal ID (Plan Specific)	X	X	X		X	1	N
49	PCC Internal Provider ID	PCC Internal ID	X	X	X		X	15	C
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, 6 = Internal ID (Plan Specific) 9 = NAPB Number (for pharmacy claims only)	X	X	X	X	X	1	N
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X	15	C
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number (for pharmacy claims only)	X	X	X	X	X	1	N
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non PCP 3 = Out of plan provider Note: This code relates to the class of the provider and a PCP does not necessarily indicate the recipient's selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X	X	X	1	C
55	Servicing Provider Type	A code indicating the type of provider rendering the service represented by this encounter or claim. (Use Servicing Provider Type values, see Table G)	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider. (Use CMS 1500 standard, see Table H)	X	X	X		X	3	C

57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X	5	N
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X	15	C
59	Authorization Type	MBHP Specific field	X	X	X	X	X	25	C

Financial Data

Most of the fields below apply to services for which reimbursement is made on a fee-for-service basis. For capitated services, the record should include fee-for-service equivalent information when available. Line item amounts are required for these fields.

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
60	Billed Charge	The amount the provider billed for the service.	X	X	X	X	X	9	SN
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. *NOTE: This field should include any withhold amount, if applicable.*	X	X	X	X	X	9	SN
62	TPL Amount	Any amount of third party liability paid by another medical coverage carrier for this service. If the TPL amount is available only at the summary level, it must be recorded on a special line on the claim which will have a record indicator value of 0. See Dollar Amounts.	X	X	X	X	X	9	SN
63	Medicare Amount	Any amount paid by Medicare for this service.	X	X	X	X	X	9	SN
64	Copay/ Coinsurance	Any co-payment amount the member paid for this service.	X	X	X	X	X	9	SN
65	Deductible	Any deductible amount the member paid for this service.	X	X	X	X	X	9	SN
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	SN
67	Dispensing Fee	The dispensing fee charged for filling the prescription.				X		9	SN
68	Net Payment	The amount the Medicaid MCE paid for this service. (Should equal Eligible Charges less COB, Medicare, Copay/Coinsurance, and Deductible.)	X	X	X	X	X	9	SN
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives.	X	X	X		X	9	SN
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion under 'Former Claim Number / Suffix' in the Data Elements Clarification Section***	X	X	X	X	X	1	C
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO) 7 = ACO-A 8 = ACO-B 9 = ACO-C	X	X	X	X	X	25	C

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
72	DRG	The DRG code used to pay for an inpatient confinement and should always be submitted in 3-digit format. One and two digit codes should be completed with leading zeros to comply. For example: a. DRG code '1' should be submitted as '001'; b. DRG code '25' should be submitted as '025'; c. DRG code '301' should be submitted as '301'. ***See discussion in the Data Element Clarifications section***.	X		X			3	C
73	EPSDT Indicator	A flag that indicates those services which are related to EPSDT: 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral		X			X	1	N
74	Family Planning Indicator	A flag that indicates whether or not this service involved family planning services, which may be matched by CMS at a higher rate: 1 = Family planning services provided 2 = Abortion services provided 3 = Sterilization services provided 4 = No family planning services provided (see Table I)	X	X		X		1	C
75	MSS/IS	*Please leave this field blank, it will be further defined at a later date.* A flag that indicates services related to MSS/IS: 1 = Maternal Support Services 2 = Infant Support Services		X				1	N
76	New Member ID	The ***"Active" Medicaid*** identification number assigned to the individual. This number is assigned by MassHealth and may change.	X	X	X	X	X	25	C

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
77	Former Claim Number	If this is not an Original claim [Record Type = 'O'], then the previous claim number that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X	15	C
78	Former Claim Suffix	If this is not an Original claim [Record Type = 'O'], then the previous claim suffix that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X	4	C
79	Record Creation Date	The date on which the record was created. ***See discussion under Record Creation Date in the Data Elements Clarification Section.***	X	X	X	X	X	8	D
80	Service Category	Service groupings from financial reports like 4B (see Table I)	X	X	X	X	X	3	C
81	Prescribing Prov. ID	Federal Tax ID or UPIN or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X		15	C
82	Date Script Written	Date prescribing provider issued the prescription.				X		8	D/YYYY MMDD
83	Compound	Indicates that the prescription was a compounded				X		1	C

	Indicator	drug. 1 = Yes 2 = No							
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X		1	C
85	Admitting Diagnosis	Diagnosis upon admission. May be different from principal diagnosis. Should not be External Injury codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/No decimal points
86	Allowable Amount	Amount allowed under the Health Plan formulary.	X	X	X	X	X	9	N
87	Attending Prov. ID	Provider ID of the provider who attended at facility. Federal Tax ID or UPIN or other State assigned provider ID.	X					15	C
88	Non-covered Days	Days not covered by Health Plan.	X		X			3	N
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD E-Code) present on the claim, it should be submitted in this field. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYY MMDD
91	Frequency	The third digit of the UB92 Bill Classification field. Submitted as a third digit in Type of Bill (#33)	X		X			1	C
92	PCC Internal Provider ID_Type	One code identifying the type of ID provided in the Provider ID above. For example, 6 = Internal ID (Plan Specific) 8 = DEA Number 9 = NABP Number 1 = NPI		X	X	X	X	1	N
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, 6 = Internal ID (Plan Specific) *9 = NABP Number* (for pharmacy claims only)	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number				X		1	N
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, *6 = Internal ID (Plan Specific)*	X					1	N
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X			4	N/HH24MI
98	Diagnosis 6	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal

									points
99	Diagnosis 7	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
101	Diagnosis 9	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
102	Diagnosis 10	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Len gth	Data Type
104	Surgical Procedure code 2	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
105	Surgical Procedure code 3	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
106	Surgical Procedure code 4	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
107	Surgical Procedure code 5	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
108	Surgical Procedure code 6	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
109	Surgical Procedure code 7	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications***	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Len gth	Data Type
		section, including clarification on ICD-10							
110	Surgical Procedure code 8	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
111	Surgical Procedure code 9	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
112	Employment	Is the patient's condition related to Employment Y N	X	X	X	X	X	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X	X	X	1	C
114	Other Accident	Is the patient's condition related to Other Accident Y N	X	X	X	X	X	1	C
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period.	X	X	X	X	X	9	N
116	Non Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any, that is not covered by the primary payer for this service.	X	X	X	X	X	9	N
117	Coinsurance	Any coinsurance amount the member paid for this service.	X	X	X	X	X	9	N
118	Void Reason Code	The reason the claim line was voided 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other	X	X	X	X	X	1	C
119	DRG Description	Description of DRG Code	X		X			132	C

#	Field Name	Definition/Description	H	P	L	R	D	Len gth	Data Type
120	DRG Type	*Values:* 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other ***Please use the accurate and specific DRG type and avoid using the value "Other". Please communicate to MassHealth any DRG types you are using that are missing from the above list***	X		X			1	C
121	DRG Version	DRG Version number associated with DRG type	X		X			3	C/ No decimal points (26.1 must be entered

									as 261)
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG: Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields***	X		X			1	C
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.***	X		X			1	C
124	Patient Pay Amount	Patient paid amount for nursing facility stays and hospitals	X		X			9	SN
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
128	Present on Admission (POA) 1	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
129	Present on Admission (POA) 2	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
130	Present on Admission (POA) 3	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
131	Present on Admission (POA) 4	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
132	Present on Admission (POA) 5	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
133	Present on Admission	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
	(POA) 6	claims (See Table M for values)							
134	Present on Admission (POA) 7	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
135	Present on Admission (POA) 8	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
136	Present on Admission (POA) 9	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
137	Present on Admission (POA) 10	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
138	Diagnosis 11	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points (26.1 must be entered as 261)
139	Present on Admission (POA) 11	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
140	Diagnosis 12	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X			7	C/ No decimal points (26.1 must be entered as 261)
141	Present on Admission (POA) 12	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
142	Diagnosis 13	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
143	Present on Admission (POA) 13	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
144	Diagnosis 14	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
145	Present on Admission (POA) 14	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
146	Diagnosis 15	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
147	Present on Admission (POA) 15	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
148	Diagnosis 16	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
149	Present on Admission (POA) 16	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
150	Diagnosis 17	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
151	Present on Admission (POA) 17	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
152	Diagnosis 18	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
153	Present on Admission (POA) 18	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
154	Diagnosis 19	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
155	Present on Admission (POA) 19	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
156	Diagnosis 20	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
157	Present on Admission (POA) 20	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
158	Diagnosis 21	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
159	Present on	This is an indicator that clarifies if the diagnosis was	X		X			1	C

	Admission (POA) 21	present at admission. This only applies to UB-04 claims (See Table M for values)							
160	Diagnosis 22	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
161	Present on Admission (POA) 22	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
162	Diagnosis 23	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
163	Present on Admission (POA) 23	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
164	Diagnosis 24	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
165	Present on Admission (POA) 24	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
166	Diagnosis 25	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
167	Present on Admission (POA) 25	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
168	Diagnosis 26	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
169	Present on Admission (POA) 26	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
170	Present on Admission (POA) EI 1	This is an indicator associated with External Injury Diagnosis 1 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
171	External Injury Diagnosis 2	If there is an External Injury Diagnosis code 2 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be

									entered as 261)
172	Present on Admission (POA) EI 2	This is an indicator associated with External Injury Diagnosis 2 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
173	External Injury Diagnosis 3	If there is an External Injury Diagnosis code 3 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
174	Present on Admission (POA) EI 3	This is an indicator associated with External Injury Diagnosis 3 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
175	External Injury Diagnosis 4	If there is an External Injury Diagnosis code 4 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
176	Present on Admission (POA) EI 4	This is an indicator associated with External Injury Diagnosis 4 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Len gth	Data Type
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
178	Present on Admission (POA) EI 5	This is an indicator associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
180	Present on Admission (POA) EI 6	This is an indicator associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
182	Present on Admission (POA) EI 7	This is an indicator associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C

183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
184	Present on Admission (POA) EI 8	This is an indicator associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
186	Present on Admission (POA) EI 9	This is an indicator associated with External Injury Diagnosis 9 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
187	External Injury Diagnosis 10	If there is an External Injury Diagnosis code 10 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
188	Present on Admission (POA) EI 10	This is an indicator associated with External Injury Diagnosis 10 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
189	External Injury Diagnosis 11	If there is an External Injury Diagnosis code 11 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
190	Present on Admission (POA) EI 11	This is an indicator associated with External Injury Diagnosis 11 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
191	External Injury Diagnosis 12	If there is an External Injury Diagnosis code 12 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X			7	C/ No decimal points (26.1 must be entered as 261)
192	Present on Admission (POA) EI 12	This is an indicator associated with External Injury Diagnosis 12 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X			1	C
193	ICD Version Qualifier	ICD9 or ICD10. The value “ICD9” must be populated on claim records with either ICD-9-CM diagnosis codes or ICD-9-CM procedure codes. The value “ICD10” must be populated on claim	X	X	X		X	5	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		records with either ICD-10-CM diagnosis codes or ICD-10-CM procedure codes. One claim record must ***never*** have a combination of ICD9 and ICD10 codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***							
194	Procedure Modifier 4	4th procedure code modifier, required, if used.	X	X	X		X	2	C
195	Service Category Type	This field describes the Type of Financial reports the service category is based on. The values are: '4B' for MCO Service Categories 'ACO' for ACO Categories 'SCO' for SCO Service Categories 'ICO' for Care One (ICO) Service Categories	X	X	X	X	X	3	C
196	Ambulance Patient Count	AMBULANCE PATIENT COUNT. REQUIRED WHEN MORE THAN ONE PATIENT IS TRANSPORTED IN THE SAME VEHICLE FOR AMBULANCE OR NON-EMERGENCY TRANSPORTATION SERVICES.		X				3	N
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.		X				5	N
198	Prescription Number	Rx Number.				X		15	C
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider identified on the claim. Taxonomy codes are National specialty codes used by providers to indicate their specialty. These codes can be found on the Website of Centers for Medicare & Medicaid Service (CMS)	X	X	X		X	10	C
200	Rate Increase Indicator	Indicates if the provider is eligible to receive the enhanced primary care rate ***for this service***, as specified in the Affordable Care Act – Section 1202 final regulations. 1=Yes 2=No 3=Unknown 4=Not Applicable **Note: If a service is considered eligible based on the ACA regulations, then the value should be equal to "1" even if the MCE is already paying the provider at the higher rate.**	X	X	X			1	C
201	Bundle Indicator	Indicates if the claim line is part of a bundle. Values: Y=Yes, the claim line is part of a bundle. All bundled lines including the line with the bundled payment should have a value of 'Y' N=No, the claim line is not part of a bundle.	X	X	X	X	X	1	C
202	Bundle Claim Number	This is the claim number of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section,***	X	X	X	X	X	15	C
203	Bundle Claim Suffix	This the claim suffix of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section,***	X	X	X	X	X	4	C
204	Value Code	Code used to relate values to identify data elements necessary to process a UB92 claim. Submit only when the value=54 for Newborn claims	X					2	AN

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
205	Value Amount	Weight of a newborn in grams. Must be present on all newborn claims when the value code "54"is submitted in Field #204	X					9	N
206	Surgical Procedure Code 10	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
207	Surgical Procedure Code 11	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
208	Surgical Procedure Code 12	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
209	Surgical Procedure Code 13	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
210	Surgical Procedure Code 14	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
211	Surgical Procedure Code 15	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
212	Surgical Procedure Code 16	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
213	Surgical Procedure Code 17	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
214	Surgical Procedure Code 18	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
215	Surgical Procedure Code 19	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
216	Surgical Procedure Code 20	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications***	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		section, including clarification on ICD-10							
217	Surgical Procedure Code 21	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
218	Surgical Procedure Code 22	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
219	Surgical Procedure Code 23	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
220	Surgical Procedure Code 24	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
221	Surgical Procedure Code 25	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X					7	C
222	Attending Prov. ID Address Location Code	Code to identify address location of Attending Provider ID in field #87	X					5	C
223	Billing Provider ID Address Location Code	Code to identify address location of Billing Provider ID in field # 58	X	X	X	X	X	5	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID in field # 81				X		5	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID in field # 47	X	X	X	X	X	5	C
226	Referring Provider ID Address Location Code	Code to identify address location of Referring Provider ID in filed # 52	X	X	X			5	C
227	Servicing Provider ID Address Location Code	Code to identify address location of Servicing Provider ID in field # 50	X	X	X	X	X	5	C
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Internal Provider ID In field **# 49**	X	X	X	X	X	5	C

* **Key to Data Types**

C Character

Includes space, A-Z (upper or lower case), 0-9

Left justified with trailing blanks.

Unrecorded or missing values are blank

N Numeric

Include 0-9.

Right justified, lead-zero filled.

Unrecorded or missing values are blank

D Date Fields

Dates should be in a numeric format. The format for all dates is eight digits in YYYYMMDD format, where YYYY represents a four digit year, MM = numeric month indicator (01 - 12); DD = numeric day indicator (01 - 31).

For example: November 22, 1963 = 19631122

Financial Fields

MassHealth prefers to receive both dollars and cents, with an **implied decimal point** before the last two digits in the data.

For example, the data string "1234567" would represent $12,345.67

Please do not include the actual decimal point in the data.

3.1 Provider Data Set with Record Layout

Data Elements
This section contains field names and definitions for the provider record. To be able to link providers across the MCEs, it is essential to accurately report as many data elements as possible.
Provider file has to contain a snap shot of complete provider data at the time the provider file is created for encounter data submission.
All locations for Provider ID and Provider ID Type are expected to be sent in the provider file, and service location - in the encounter file. For Billing Providers the primary address location should be included in the encounter file.
To reflect the changes in provider contract status, an MCE should provide one record per provider/location with the effective and term dates populated accurately. In this case, the effective and term dates per Provider ID/Provider ID Type/location will not overlap.
Effective and Term dates should ***not*** be blank. Providers, who are enrolled with the MCE at the time of the data submission, are expected to have "End of Time" as a Term date in that submission. The preferred value for the "End of Time" field is '99991231'.
Providers with multiple servicing sites or addresses ***must*** have different IDs for each location.

File Processing
All fields should be submitted when available including:

1. Tax Id Number when available (filed#30);
2. APCD ORG ID when available in APCD data (filed#34);

Reject the file if:

a. NPI is missing on more than 20% of the records. At least 80% of the records should have NPI.
b. Provider Type is missing on more than 20% of the records. At least 80% of the records should have Provider Type entered.
c. Provider ID, or Provider ID Type, or Provider ID Location Code are missing.

The following fields are 100% required on all records:

1. Org. Code (Field #1),
2. Provider ID (Field #2).
3. Provider ID Type (Field #3).
4. Provider last Name (Field #4).
5. Provider First Name (Field #5).
6. Provider Office Address Street (Field #8).
7. Provider Office Address City (Field #9).
8. Provider Office Address State (Field #10).
9. Provider Office Address Zip (Field #11).
10. Provider Mailing Address Street (Field #12).
11. Provider Mailing Address City (Field #13).
12. Provider Mailing Address State (Field #14).
13. Provider Mailing Address zip (Field #15).
14. Provider Effective Date (Field #18).
15. Provider Term Date (Field #19).
16. Provider DEA Number when applicable (Field #24).
17. Provider ID Address Location Code (Field#36)
18. Provider Bundle ID (Field #40)

#	Field Name	Definition/Description	Length	Data Type
1	Org.Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N
2	Provider ID	Multiple formats for the same Provider ID must be avoided. For example, ID '00001111' and '001111' should be submitted with one consistent format if it indicates the same ID for the same provider.	15	C
3	Provider ID Type	A code identifying the type of ID provided in the Provider ID above. For example, 1 = NPI 6 = Internal Plan ID 8 = DEA Number (For Pharmacy claims ONLY) 9 = NABP Number (For Pharmacy claims ONLY)	1	C
4	License Number	State license number.	9	C
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider ID).	10	C
6	Provider Last Name	Last name of provider. In case of an organization or entity or hospital, name should be entered in this field only. Please avoid using abbreviations and enter names consistently. For example, enter "Massachusetts General Hospital" instead of "MGH". Length increased to 200 characters	200	C
7	Provider First Name	First name of the provider Please submit First Name consistently. In case of an organization or entity or hospital, name should be entered in "Provider Last Name" field above and **not** in this field. Length increased to 100 characters	100	C
8	Provider Office Address Street	Street address where services were rendered. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
9	Provider Office Address City	City where services were rendered.	20	C

10	Provider Office Address State	State where services were rendered.	2	C
11	Provider Office Address ZIP	Zip where services were rendered. ZIP+4	9	C
12	Provider Mailing Address Street	Street address where correspondence is received. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider	45	C
13	Provider Mailing Address City	City where correspondence is received.	20	C
14	Provider Mailing Address State	State where correspondence is received.	2	C
15	Provider Mailing Address ZIP	Zip where correspondence is received. ZIP+4	9	C
16	Provider Type	Please use the values from Table G. **Note** that value "-4" for "Incomplete/No Information" option has been removed.	3	N

#	Field Name	Definition/Description	Length	Data Type
17	Filler		3	C
18	Provider Effective Date	Date provider becomes eligible to perform services.	8	D
19	Provider Term Date	Date provider is no longer eligible to perform services.	8	D
20	Provider Non-par Indicator	Non-participating provider indicator. 1 non-participating provider 2 participating provider	1	C
21	Provider Network ID	The network the provider is affiliated to by the Health Plan (internal plan ID).	15	C
22	PCC Provider ID	Required for PCCs enrolled with the MCE.	15	C
23	Panel Open Indicator	Is the provider accepting new patients? 1 Accepting new patients 2 Not accepting new patients	1	C
24	Provider DEA Number	Provider DEA Number	11	C
25	Provider Type Description	Description of the provider type	50	C
26	National Provider Identifier (NPI)	National Provider Identifier issued by the National Plan and Provider Enumeration System (NPPES). It is required on all claims.	10	C
27	Medicare ID Number		15	C
28	Social Security Number	Provider's SSN is 9 digits field and should be entered with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.	9	C
29	NABP Number		9	C
30	Tax ID Number	Tax ID Number is primarily the Federal Employee Identification Number (FEIN); however, when Providers don't have Tax ID	9	C

		Number for the reasons like being sole proprietors or small business owners without employees, provider's SSN should be entered in both fields, # 28 and #30, in same 9 digits format with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.		
31	PCC Provider ID Type	Required for PCCs enrolled with the MCE.	1	C
32	Gender Code	"M" for Male, "F" for Female, and "O" for Other	1	C

#	Field Name	Definition/Description	Length	Data Type
33	Primary Care Eligibility Indicator	Provider is eligible to receive enhanced Medicare rate for their primary care services. This indicator should follow the CMS and MassHealth regulations on provider eligibility for Affordable Care Act – Section 1202. 0=Yes, Eligible based on 60% Attestation 1=Yes, Eligible based on Board Certification 2=No, Not Eligible 3=Unknown 4=Not Applicable **Note: The values '0' and '1' indicating provider eligibility for the "ACA Section 1202" Rate Increase should be only applicable when providers have active contracts with MCEs. If a provider contract gets terminated then the provider would no longer be eligible for the rate increase, and the value for this flag would be '2' (Not Eligible).** **The assumption is that eligible providers are either eligible based on Board Certification or 60% attestation. In the case where the MCE receives a 60% attestation from a provider that has already been determined to be eligible based on Board Certification then MCE should use value "1".**	1	C
34	APCD ORG ID	This is a new field added to get the APCD Provider Organization ID (OrgID) for the provider. Length is 6 characters. It should be submitted for all providers whose Org ID had been submitted to APCD.	6	C
35	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims Example: 999999999A	10	C
36	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2.	5	C
37	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID in Field # 22.	5	C
38	Provider Network ID TYPE	Type of Provider Network ID in Field # 21.	1	N
39	Provider Network ID Address Location Code	Code to identify address location of Provider Network ID in Field # 21.	5	C
40	Provider Bundle ID	ID to tie together all the IDs for a particular provider	15	C
41	Provider ID Primary Address Location Indicator	Y/N value to indicate primary address location	1	C

Example of Provider Bundle ID

Org. Code	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider ID Primary Address Location Indicator	Provider Last Name	Provider First Name
888	1234569	6	A	65656	N	Smith	John
888	1234568	6	B	65656	N	Smith	John
888	1234567	6	C	65656	Y	Smith	John
888	1234566	6	D	65656	N	Smith	John

Provider Error Process:

1. Provider records with null ID and/or null ID Type do not get loaded into MH DW. Such records get rejected and returned in the provider error response file.

2. If duplicate records per provider ID, Provider ID Type, Provider Address Location, and Provider Term Date are ***erroneously*** submitted, one record will be accepted based on "best fit" logic and all other records will be rejected and returned in the provider error file.

3. "Best" fit logic picks one record per provider ID, provider ID Type and provider Term Date in a provider file, based on the record that has the most populated information (NPI, provider name, address, tax ID, license number, and Medicaid Number, respectively).

4. Records sent with "null" or missing effective/term dates, will also be returned to the MCEs in the provider error response file. The MCE is expected to correct and resubmit these records in the Correction file data submissions.

5. A Correction file for provider records rejected for any of the reasons above should be submitted with a zipped Correction file for the ***same*** submission.

3.2 MCE Internal Provider Type Data Set Elements with Record Layout

Data Elements

This section contains field names and definitions for the provider type record that is based on the Provider Types that are **internally** used by the MCE. This is different from MassHealth Provider Types submitted in the Provider Data Set defined above. ***This table should only have providers who have an internal provider type code. In other words, this table should not have providers with missing internal provider type code.***

#	Field Name	Definition/Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N
2	Provider ID	Provider ID.	15	C
3	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example, 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI	1	N
4	Internal Provider Type Code	Provider Type code as defined internally by the MCE	6	C
5	Internal Provider Type Description	Description of Provider Type code as defined internally by the MCE	120	C
6	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2	5	C

3.3 Provider Specialty Data Set Elements

Data Elements

This section contains field names and definitions for the provider specialty record. If a provider has multiple specialties, please provide one record for each specialty per provider.

#	Field Name	Definition/Description	Length	Data Type
1	Org.Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N
2	Provider ID	Provider ID. Federal Tax ID, UPIN or Health Plan ID.	15	C
3	Provider Specialty	Please use the values contained in Table H. If there are provider specialties not contained in table H, assign them a new three digit number. List the description of the new values in the Provider Specialty Description field.	3	C
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.	8	D

	Field Name	Definition/Description		
5	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example: 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI	1	C
6	Provider Specialty Description	Description of the Provider Specialty	50	C
7	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2.	5	C

3.4 Additional Reference Data Set Elements

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description		
1	Org. Code	Unique ID assigned to each submitting organization in MassHeath DW	4	N
2	ATHTYP	Two digit code identifying the type of service.	6	C
3	ATHTYP DESCRIPTION	Description for the ATHYTYP codes.	100	C

Claim Type Data Set Elements

#	Field Name	Description		
1	Org. Code	Unique ID assigned to each submitting organization in MassHeath DW	3	N
2	CLATYP	Code identifying a service.	6	C
3	CLATYP DESCRIPTION	Description for the CLATYP codes.	100	C

Group Number Data Set Elements

#	Field Name	Description		
1	Org. Code	Unique ID assigned to each submitting organization in MassHeath DW	3	N
2	Member Rating Category	Description for the Member Rating Category.	50	C
3	DMA/DMH Indicator	Description for the DMA/DMH Indicator.	50	C
4	Eligibility Group Name	Description for the Eligibility Group Name.	100	C
5	Eligibility Group Number	Six digit number identifying the Eligibility Group.	10	N
6	MMIS Plan Type	Two digit code identifying the MMIS Eligibility Plan Type.	2	C

Service Class Data Set Elements

#	Field Name	Description		
1	Org. Code	Unique ID assigned to each submitting organization in MassHeath DW	3	N
2	Service Class	Code identifying a service class.	10	C
3	Description	Description of service class codes	100	C

Services Data Set Elements				
#	**Field Name**	**Description**		
1	Org. Code	Unique ID assigned to each submitting organization in MassHeath DW	3	N
2	SVCLVLE	Description of Service Level I.	60	C
3	SVCLVLMHSA	Description of Service Level II.	90	C
4	SVCGRP	Description of Service Level III.	100	C
5	SVCDESC	Description of Service Level IV.	120	C
6	UNITTYP	Description of Unit Type.	4	C
7	UNITCONVE	Unit Conversion Value. This must be a positive number greater than zero.	12	N
8	ATHTYP	Authorization Type Code.	1	C
9	SVCCOD_REFSERVICES	Service Code.	6	C
10	CLATYP_REFSERVICES	Claim Type Code.	2	C
11	MOD1_REFSERVICES	Modifier Code.	2	C
12	ID_SERVICES	ID Services Value.	10	N
13	CBHI_FLAG	An indicator to distinguish CBHI Services	10	C
14	SERVICE_24_HOUR	Specifies if it was 24-Hour or Non-24-Hour Service (or other descriptions such as P4P)	11	C
15	INTERMEDIATE_SVCLVLE	Specifies what kind of Intermediate Service Level was provided	50	C
16	SVCLVLI	Specifies service level provided	60	C
17	MHSAEM	Service provided: whether it was EM, or MH, or NA, or SA	2	C
18	SVCDIRECTORY	Service Directory	82	C

4.0 Encounter Record Layout Amendment Process and Layout

1. There are no constraints on timing of the submission of amendment feeds. We will be able to handle amendments sent as part of a regular submission in a quarterly/monthly cycle or as one-off submissions outside the schedule. The format of this file is the same as the Encounter Data file. All columns should represent the "after-snap-shot" – i.e. data should be post-changes. This feed should be submitted with the standard metadata file.

2. Record type 'A' is used to identify an amendment record. While the record type of an amendment record will be 'A', it will inherit the record type of the record it is amending when it is inserted into our database.

3. Amendment processing has been created to allow MCEs to make retroactive changes to existing claims. By existing claims, we mean those that have been accepted by MassHealth after they either passed the weeding logic or were manually overridden.

4. Dollar amount changes on the claim happening on the source system – like adjustments, voids – should still be handled via existing process set up to handle those kinds of transactions.

5. Amendment claims must be submitted in a format that reflects the current processing logic. A claim submitted prior to the introduction of Commonwealth Care, when amended must have valid data in the Group Number field. In addition, all provider data must point to the current provider reference data.

6. We expect that this will primarily be used to reflect retroactive dimension changes – such as Member ID, Servicing Category etc. If MCEs have issues with constructing original claim, they can send MassHealth a list of claim number/suffixes and we can send a copy of the latest version of the data for that claim as exists in our data-warehouse -- back to the MCE.

7. The primary key for the amendment file will be the combination of claim number/suffix and former claim number/suffix. This combination must exist in our encounter database. If the claim number + claim suffix of the 'A' record is not found in our database, the record will be rejected with error code 11--Active Original Claim No-Claim Suffix Not Found.

8. Multiple amendments to the same record in the same feed will not be allowed and will be rejected with error code 10--Duplicate Claim No-Claim Suffix -- in same feed.

9. The amendment process will have the same iterative error process as the regular submission.

5.0 Error Handling

MassHealth will validate the feeds received from the MCEs and MBHP and return files containing erroneous records back to the MCEs and MBHP for correction and resubmission. The error rate in the initial submission should be no more than 3% for the data to be considered complete and accurate. The format of the error files will be the same as the input record layout described above with 2 fields appended as the last 2 fields on the record layout. These will be the erroneous field number and the error code for that field. Section 8.0 Quantity & Quality Edits lays out the expectation for each field in the record format for the feed. In addition to these edits, MassHealth will also subject the records to some intra-record validation tests. These may include validation checks like "net amount <= gross amount", "non-unique claim number + claim suffix combination", etc. Error checking is likely to evolve with time therefore a complete list of all pseudo-columns and error codes will accompany the rejected records returned to the MCEs and MBHP. A list is published below.

Error Codes

Error Code	Description
1	Incorrect Data Type
2	Invalid Format
3	Missing value
4	Code missing from reference data
5	Invalid Date.
6	Admissions Date is greater than Discharge Date
7	Discharge Date is less than Admissions Date
8	Paid Date is less than Admission or Discharge or Service Dates
9	Date is prior to Birth Date
10	Duplicate Claim No-Claim Suffix -- in same feed
11	Active Original Claim No-Claim Suffix Not Found
12	Bad Zip Code
13	Replacement received for a voided record
14	Date is in the future
15	From Service Date is greater than To Service Date
16	To Service Date is less than From Service Date
17	Cannot be Negative
18	Non HIPAA/Standard code.
19	Bad Metadata File.
20	Local Code Not present in MassHealth DW.
21	Cannot be Zero.
22	Former Claim No-Claim Suffix fields should not contain data for Original Claim
23	Only Original claims allowed in the Initial feed
24	Duplicate Claim No-Claim Suffix -- from prior submission
25	Filler
26	Original Claim No-Claim Suffix, Former Claim No-Claim Suffix -- in same feed

Error Codes (cont'd):

Error Code	Description
27	Metadata - No metadata file found or file is empty.
28	Metadata - MCE_Id incorrect for the plan.
29	Metadata - MCE_ID not found in metadata file.
30	Metadata - Date_Created not found in metadata file.
31	Metadata - Date_Created is not a valid date.
32	Metadata - Data_File_Name not found in metadata file.
33	Metadata - Data_File_Name does not exist or is not a regular file.
34	Metadata - Pro_file_Name not found in metadata file.
35	Metadata - Pro_file_Name does not exist or is not a regular file.
36	Metadata - Pro_Spec_Name not found in metadata file.
37	Metadata - Pro_Spec_Name does not exist or is not a regular file.
38	Metadata - Total_Records not found in metadata file.
39	Metadata - Total_Records does not match actual record count.
40	Metadata - Total_Net_Payments not found in metadata file.
41	Metadata - Total_Net_Payments does not match actual sum of dollar amount.
42	Metadata - Time_Period_From not found in metadata file.
43	Metadata - Time_Period_From is not a valid date.
44	Metadata - Time_Period_To not found in metadata file.
45	Metadata - Time_Period_To is not a valid date.
46	Metadata - Return_To not found in metadata file.
47	Metadata - Type_Of_Feed not found in metadata file.
48	Metadata - Type_Of_Feed contains invalid value. Refer to the spec for valid values.
49	Metadata - Metadata - Ref_Services_File_Name not found in metadata file.
50	Metadata - Ref_Services_File_Name does not exist or is not a regular file.
51	Metadata - ATHTYP_File_Name not found in metadata file.
52	Metadata - ATHTYP_File_Name does not exist or is not a regular file.
53	Metadata - GRPNUM_File_Name not found in metadata file.
54	Metadata - GRPNUM_File_Name does not exist or is not a regular file.
55	Metadata - SVCCLS_File_Name not found in metadata file.
56	Metadata - SVCCLS_File_Name does not exist or is not a regular file.
57	Metadata - CLATYP_File_Name not found in metadata file.
58	Metadata - CLATYP_File_Name does not exist or is not a regular file.
59	RefService not found.
60	If former claim number filled in, so must former_claim_suffix.
70	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (To Service Date >=10/01/2015)
71	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (Discharge Date>=10/01/2015)
*72**	(Denial Code not in Denied_Claims file) Claim Number/Suffix in Denied_Claims_Reason_Code file not in Denied_Claims file
*73**	*Claim Number/Suffix in Denied_Claims file not in Denied_Claims_Reason_Code file*
74	Correction to a claim that is not in MH DW
61	*Missing Provider NPI – Not used at present*
62	Metadata - Pro_MCEType_Name not found in metadata file.
63	Metadata - Pro_MCEType_Name does not exist or is not a regular file.

*Applies to the Denied Claims submissions only

The MCEs and MBHP should resubmit corrected records within a week of receiving the error files from MassHealth. This process will be repeated until the number of validation errors falls below a MassHealth defined threshold. Refer to the "Encounter Data" section in the MassHealth Managed Care Organization Contract, for more details on the action required when data submission is not in compliance with Encounter Data requirements.

6.0 Media Requirements

Format

File Type: PKZIP/WINZIP compressed plain text file
Character Set: ASCII

All submitted files should be ***pipe-delimited.*** Please compress the data file using PKZIP/WINZIP or compatible program. All records in the data file should follow the record layout specified in section 4.0 where the length represents the maximum length of each field. Padding fields with 0s or spaces is ***not*** required.

Each record should end with the standard MS Windows text file end-of-line marker ("\r\n" - a carriage control followed by a new line).

Filename

The Zip file name should conform to the following naming convention:

PPP_Claims_YYYYMMDD.zip

Where "YYYYMMDD" is the date of file creation (4 digit year, 2 digit month, 2 digit day) and PPP identifies the MCE according to the following:

MCOs:
BMC - Boston Medical Center HealthNet Plan
CHA - Cambridge Network Health
FLN- Fallon Community Health Plan
MBH - Massachusetts Behavioral Health Partnership
NHP - Neighborhood Health Plan
HNE - Health New England
CAR - CeltiCare

SCOs:
CCA - Commonwealth Care Alliance
UHC – United HealthCare
NAV - Navicare
SWH - Senior Whole Health
TFT – Tufts Health Plan
BHP – BMC HealthNet Plan

One Care (ICO):
CCI - Commonwealth Care Alliance
NWI – Cambridge Network Health
FTC – Fallon Total Care

For example, the Boston Medical Center HealthNet Plan submission created on 7/1/2001 would have the name BMC_Claims_20010701.zip

The Manual Override File

The manual override file should be named PPP_Claims_YYYYMMDD_**MO**. The _MO files should be sent only after the error file has been returned to the MCEs, and the MCEs have re-submitted a corrected file. The manual override file should have a file type of EMO in the metadata file.

The Zip File should contain:

The Encounter Data file
The Provider data file
The Provider specialty file
The MCE Internal Provider Type file
The Manual Override file (if applicable)
The Service Reference file (MBHP Only)
The Service Class Codes file (MBHP Only)
The Authorization Type Codes file (MBHP Only)
The Claim Type Codes file (MBHP Only)
The Group Number Codes file (MBHP Only)

Additional Documentation File or Metadata file

Metadata file

Please submit an additional file called **metadata.txt** which contains the following Key Value Pairs. A regular submission or error submission file should have a file type of ENC. The manual override file should have a file type of EMO in the metadata file.

	ENC/EMO
MCE_Id="Value" (MCO: FLN, NHP, BMC, CHA, MBH, HNE, CAR) (SCO: CCA, UHC, NAV, SWH, TFT, BHP) (One Care-ICO: CCI, NWI, FTC)	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Data_File_Name="Value"	Mandatory
Pro_File_Name="Value"	Mandatory
Pro_Spec_Name="Value"	Mandatory
Pro_MCEType_Name=”Value”	Mandatory
Total_Records="Value"	Mandatory
Total_Net_Payments="Value"	Mandatory
Time_Period_From="Value” (YYYYMMDD)	Mandatory
Time_Period_To="Value" (YYYYMMDD)	Mandatory
Return_To="email address"	Mandatory
Type_Of_Feed="Value" (ENC/EMO)	Mandatory
Ref_Services_File_Name ="Value"	Optional
SVCCLS_File_Name ="Value"	Optional
ATHTYP_File_Name ="Value"	Optional
CLATYP_File_Name ="Value"	Optional
GRPNUM_File_Name ="Value"	Optional

a) Files in the metadata file must match actual files in the archive in case and extension.
b) Send a zero byte None.txt for missing files - provider or specialty and set corresponding field value to "None.txt"

c) Make sure that archive file sent down each time has a unique name - this is because -- if the job that we will run to pick up the files -- does not run on a day for some reason, there is a risk of losing the original file.
d) Discrepancy between actual feed and Metadata file fields: Total_Net_Payments and or Total_Records would result in entire feed being rejected.
e) The key in the key-value pair (example Total_Net_Payments) must match in spelling to what is on the spec.
f) From a processing perspective there is no difference between the original submission, an error file, or an Amendment file. All these types of submissions should use ENC as the type of feed.

Monthly Financial Report -

some additional updates might be introduced later

This is a stand-alone text file submitted monthly separate from encounter data submission; however, it must be always submitted ***after*** the manual override file. Please follow instructions in Section 1.1 "Data Requirements".

Monthly Financial Report is submitted as a pipe-delimited text file based on the following specifications:

1. File name should conform to the following naming convention:
   MCE_FinReport_YYYYMMDD.txt where the date reflects the date of a file submission.

   Example:
   A report submitted by Boston Medical Center HealthNet Plan in May of 2015 for the month of March of 2015 would be named: **BMC_FinReport_20150531.txt**

2. Along with the report file, a confirmation file named **"mce_fin_done.txt"** should be submitted. This file should contain one field only indicating the name of the financial report submitted.

   Example:
   mce_fin_done.txt submitted along with **BMC_FinReport_20150531.txt** file will have the following content:
   "MCE_FINREP_FILE="BMC_FinReport_20150531.txt"

   First report record is a mandatory header record with the following details:
   MCE_ID|Reporting_YearMonth|Date_Created|Total_Records|Return_To

   Example:

   BMC|201503|20150531|25|abc.xyz@bmchp.org

3. Definition of header record by data element:

#	Field Name	Definition
1	MCE_ID	One of the following values: MCO: FLN,NHP,BMC,CHA,MBH,HNE,CAR; SCO: CCA, UHC, NAV, SWH, TFT, BHP; One Care-ICO: CCI, NWI, FTC.
2	Reporting_YearMonth	Must be the year and the month of the reporting month in "YYYYMM" format. (Same as "YearMonth" in the report).
3	Date_Created	Must be the date of submission with format "YYYYMMDD"
4	Total_Records	Number of records in the report excluding the header record.
5	Return_To	Must have the email address of the MCE contact person(s).

4. Data records should follow the header record with the layout described below:

#	Field Name	Definition	Length	Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	Number
2	Service Category	Service Category as defined in Tables I-A, I-B, I-C	3	Text
3	Description	Description of Service Category	120	Text
4	Total Number Of Claim Lines	Total number of claim lines per Service Category	10	Number
5	Total Net Payment	Total expenses per Service Category	15	*Number/No Decimal Point
6	YearMonth	The Year and Month of the report based on the dates of service on the claims. There is only one value per monthly report. See example below for August 2014 report.	6	Text

*MassHealth prefers to receive dollars and cents with an **implied decimal point** before the last two digits in the data. Actual decimal point must not be included in dollar amounts.

For example, a data string "1234567" would represent $12,345.67.

Report Example:

BMC|201503|20150531|25|abc.xyz@bmchp.org
997|5|Behavioral Health - Emergency Services|148|12365400|201408
997|9|Facility - Medical/Surgical|321|987456|201408
997|13|Laboratory|654|321456|201408
……

Note: No Pipes are allowed in the values of any above mentioned elements

Potential Duplicate Claims

As an effort to eliminate duplicate encounter claims, DW will prepare Potentially Duplicate Claims reports and send them to respective MCEs after the monthly submission files are loaded.
The claims in submission will be compared to the historical encounter data of the previous 5 years to detect any potential duplicate claims.
The format of Potential Duplicate Claims report will be the same as the format of the input file with the duplicated claims lines bundled together.
The report will be posted on SFTP server along with the regular Error reports.

Secure FTP Server

MassHealth has set up a Secure FTP server for exchanging data with the MCEs. Details of the server are below:

Sever: virtualgateway**dw**.ehs.state.ma.us ID currently set up for MCOs: fln, nhp, bmc, cha, mbhp, gu02 (CAR), gu04 (HNE).
ID currently set up for SCOs: swh, uhc, nav, cca, tft, bhp.
ID currently set up for One Care (ICOs): cci, nwi, ftc.
Home directory :/<mce>: example /nhp.

- Each home directory currently contains following sub directories *ehs_dw* : production folder for exchanging encounter data and error reports.
- *test_masshealth*: used by MassHealth for testing purpose.
- *test_mco*: available for mce to send any test files or adhoc data to MassHealth.

Sending Encounter data

Transfer encounter data with format and content as described in sections above - to the production folder on the server. After the data transfer is complete, include a zero byte file called *mce_done.txt.*

- Please refrain from sending file with the same name more than once to the server.
- Also, please make sure not to submit more than one encounter or member file at the same time.

Receiving Error reports

After the data has been processed, an error zip file (beginning with err) will be posted to the production folder. A notification email will be sent to the email address provided in the Metadata feed. Please note that the error file will be available on the server for a period of 30 days. MassHealth may need to revise the retention period in the future, based on available disk space on the server. If you post a file and do not receive email message about the error file back in 7 business days, please contact MassHealth.

CMS Internet Security Policy –
(*The policy will be updated*)

DATE OF ISSUANCE: November 24, 1998

SUBJECT:
Internet Communications Security and Appropriate Use Policy and Guidelines for CMS Privacy Act-protected and other Sensitive CMS Information.

1. Purpose.

This bulletin formalizes the policy and guidelines for the security and appropriate use of the Internet to transmit CMS Privacy Act-protected and other sensitive CMS information.

2. Effective Date.

This bulletin is effective as of the date of issuance.

3. Expiration Date.

This bulletin remains in effect until superseded or canceled.

4. Introduction.

The Internet is the fastest growing telecommunications medium in our history. This growth and the easy access it affords has significantly enhanced the opportunity to use advanced information technology for both the public and private sectors. It provides unprecedented opportunities for interaction and data sharing among health care providers, CMS contractors, CMS components, State agencies acting as CMS agents, Medicare and Medicaid beneficiaries, and researchers.
However, the advantages provided by the Internet come with a significantly greater element of risk to the confidentiality and integrity of information. The very nature of the Internet communication mechanisms means that security risks cannot be totally eliminated. Up to now, because of these security risks and the need to research security requirements vis-a-vis the Internet, CMS has prohibited the use of the Internet for the transmission of all CMS Privacy Act-protected and other sensitive CMS information by its components and Medicare/Medicaid partners, as well as other entities authorized to use this data.

The Privacy Act of 1974 mandates that federal information systems must protect the confidentiality of individually-identifiable data. Section 5 U.S.C. 552a (e) (10) of the Act is very clear; federal systems must: "...establish appropriate administrative, technical, and physical safeguards to insure the security and confidentiality of records and to protect against any anticipated threats or hazards to their security or integrity which could result in substantial harm, embarrassment, inconvenience, or unfairness to any individual on whom information is maintained." One of CMS's primary responsibilities is to assure the security of the Privacy Act-protected and other sensitive information it collects, produces, and disseminates in the course of conducting its operations. CMS views this responsibility as a covenant with its beneficiaries, personnel, and health care providers. This responsibility is also assumed by CMS's contractors, State agencies acting as CMS agents, other government organizations, as well as any entity that has been authorized access to CMS information resources as a party to a Data Release Agreement with CMS.

However, CMS is also aware that there is a growing demand for use of the Internet for inexpensive transmission of Privacy Act-protected and other sensitive information. CMS has a responsibility to accommodate this desire

as long as it can be assured that proper steps are being taken to maintain an acceptable level of security for the information involved.

This issuance is intended to establish the basic security requirements that must be addressed for use of the Internet to transmit CMS Privacy Act-protected and/or other sensitive CMS information.

The term "CMS Privacy Act-protected Data and other sensitive CMS information" is used throughout this document. This phrase refers to data which, if disclosed, could result in harm to the agency or individual persons. Examples include:

> All individually identifiable data held in systems of records. Also included are automated systems of records subject to the Privacy Act, which contain information that meets the qualifications for Exemption 6 of the Freedom of Information Act; i.e., for which unauthorized disclosure would constitute a "clearly unwarranted invasion of personal privacy" likely to lead to specific detrimental consequences for the individual in terms of financial, employment, medical, psychological, or social standing.
>
> Payment information that is used to authorize or make cash payments to individuals or organizations. These data are usually stored in production application files and systems, and include benefits information, such as that found at the Social Security Administration (SSA), and payroll information. Such information also includes databases that the user has the authority and capability to use and/or alter. As modification of such records could cause an improper payment, these records must be adequately protected.
>
> Proprietary information that has value in and of itself and which must be protected from unauthorized disclosure.
>
> Computerized correspondence and documents that are considered highly sensitive and/or critical to an organization and which must be protected from unauthorized alteration and/or premature disclosure.

5. Policy

This Guide establishes the fundamental rules and systems security requirements for the use of the Internet to transmit CMS Privacy Act-protected and other sensitive CMS information collected, maintained, and disseminated by CMS, its contractors, and agents.

It is permissible to use the Internet for transmission of CMS Privacy Act-protected and/or other sensitive CMS information, as long as an acceptable method of encryption is utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information. Detailed guidance is provided below in item 7.

6. Scope.

This policy covers all systems or processes which use the Internet, or interface with the Internet, to transmit CMS Privacy Act-protected and/or other sensitive CMS information, including Virtual Private Network (VPN) and tunneling implementations over the Internet. Non-Internet Medicare/Medicaid data communications processes (e.g., use of private or value added networks) are not changed or affected by the Internet Policy.

This policy covers Internet data transmission only. It does not cover local data-at-rest or local host or network protections. Sensitive data-at-rest must still be protected by all necessary measures, in conformity with the guidelines/rules which govern the entity's possession of the data. Entities must use due diligence in exercising this responsibility.

Local site networks must also be protected against attack and penetration from the Internet with the use of firewalls and other protections. Such protective measures are outside the scope of this document, but are essential to providing adequate local security for data and the local networks and ADP systems which support it.

7. Acceptable Methods

CMS Privacy Act-protected and/or other sensitive CMS information sent over the Internet must be accessed only by authorized parties. Technologies that allow users to prove they are who they say they are (authentication or identification) and the organized scrambling of data (encryption) to avoid inappropriate disclosure or modification must be used to insure that data travels safely over the Internet and is only disclosed to authorized parties. Encryption must be at a sufficient level of security to protect against the cipher being readily broken and the data compromised. The length of the key and the quality of the encryption framework and algorithm must be increased over time as new weaknesses are discovered and processing power increases.

User authentication or identification must be coupled with the encryption and data transmission processes to be certain that confidential data is delivered only to authorized parties. There are a number of effective means for authentication or identification which are sufficiently trustworthy to be used, including both in-band authentication and out-of-band identification methods. Passwords may be sent over the Internet only when encrypted.

(footnote)1 We note that the Health Insurance Portability and Accountability Act of 1966 (HIPAA) calls for stringent security protection for electronic health information both while maintained and while in transmission. The proposed Security Standard called for by HIPAA was published in the Federal Register on August 12, 1998. The public had until October 13, 1998, to comment on the proposed regulation. Based on public comments, a final regulation is planned for late 1999. Policy guidance contained in this bulletin is consistent with the proposed HIPAA security requirements.

ENCRYPTION MODELS AND APPROACHES

Figure 1 depicts three generalized configurations of connectivity to the Internet. The generic model is not intended to be a literal mirror of the actual Internet interface configuration, but is intended to show that the encryption process takes place prior to information being presented to the Internet for transmission, and the decryption process after reception from the Internet. A large organization would be very likely to have the Internet Server/Gateway on their premises while a small organization would likely have only the Internet Client, e.g., a browser, on premises with the Internet Server at an Internet Service Provider (ISP). The Small User and Large User examples offer a more detailed depiction of the functional relationships involved.

The Encryption/Decryption process depicted graphically represents a number of different approaches. This process could involve encryption of files prior to transmittal, or it could be implemented through hardware or software functionality. The diagram does not intend to dictate how the process is to be accomplished, only that it must take place prior to introduction to the
Internet. The "Boundary" on the diagrams represents the point at which security control passes from the local user. It lies on the user side of the Internet Server and may be at a local site or at an Internet Service Provider depending upon the configuration.

FIGURE 1: INTERNET COMMUNICATIONS EXAMPLES in PDF.

Acceptable Approaches to Internet Usage

The method(s) employed by all users of CMS Privacy Act-protected and/or other sensitive CMS information must come under one of the approaches to encryption and at least one of the authentication or identification approaches. The use of multiple authentication or identification approaches is also permissible. These approaches are as generic as possible and as open to specific implementations as possible, to provide maximum user flexibility within the allowable limits of security and manageability.

Note the distinction that is made between the processes of "authentication" and "identification". In this Internet Policy, the terms "Authentication" and "Identification" are used in the following sense. They should not be interpreted as terms of art from any other source. Authentication refers to generally automated and formalized methods of establishing the authorized nature of a communications partner over the Internet communications data channel itself, generally called an "in-band process." Identification refers to less formal methods of establishing the authorized nature of a communications partner, which are usually manual, involve human interaction, and do not use the Internet data channel itself, but another "out-of-band" path such as the telephone or US mail.

The listed approaches provide encryption and authentication/identification techniques which are acceptable for use in safeguarding CMS Privacy Act-protected and/or other sensitive CMS information when it is transmitted over the Internet.

In summary, a complete Internet communications implementation must include adequate encryption, employment of authentication or identification of communications partners, and a management scheme to incorporate effective password/key management systems.

ACCEPTABLE ENCRYPTION APPROACHES

Note: As of November 1998, a level of encryption protection equivalent to that provided by an algorithm such as Triple 56 bit DES (defined as 112 bit equivalent) for symmetric encryption, 1024 bit algorithms for asymmetric systems, and 160 bits for the emerging Elliptical Curve systems is recognized by CMS as minimally acceptable. CMS reserves the right to increase these minimum levels when deemed necessary by advances in techniques and capabilities associated with the processes used by attackers to break encryption (for example, a brute-force exhaustive search).

HARDWARE-BASED ENCRYPTION:

1. Hardware encryptors - While likely to be reserved for the largest traffic volumes to a very limited number of Internet sites, such symmetric password "private" key devices (such as link encryptors) are acceptable.

SOFTWARE-BASED ENCRYPTION:

2. Secure Sockets Layer (SSL) (Sometimes referred to as Transport Layer Security - TLS) implementations - At a minimum SSL level of Version 3.0, standard commercial implementations of PKI, or some variation thereof, implemented in the Secure Sockets Layer are acceptable.

3. S-MIME - Standard commercial implementations of encryption in the e-mail layer are acceptable.

4. In-stream - Encryption implementations in the transport layer, such as pre-agreed passwords, are acceptable.

5.Offline - Encryption/decryption of files at the user sites before entering the data communications process is acceptable. These encrypted files would then be attached to or enveloped (tunneled) within an unencrypted header and/or transmission.

ACCEPTABLE AUTHENTICATION APPROACHES

AUTHENTICATION (This function is accomplished over the Internet, and is referred to as an "in-band" process.)

1. Formal Certificate Authority-based use of digital certificates is acceptable.

2. Locally-managed digital certificates are acceptable, providing all parties to the communication are covered by the certificates.

3. Self-authentication, as in internal control of symmetric "private" keys, is acceptable.

4. Tokens or "smart cards" are acceptable for authentication. In-band tokens involve overall network control of the token database for all parties.

ACCEPTABLE IDENTIFICATION APPROACHES

IDENTIFICATION (The process of identification takes place outside of the Internet connection and is referred to as an "out-of-band" process.)

1. Telephonic identification of users and/or password exchange is acceptable.

2. Exchange of passwords and identities by U.S. Certified Mail is acceptable.

3. Exchange of passwords and identities by bonded messenger is acceptable.

4. Direct personal contact exchange of passwords and identities between users is acceptable.

5. Tokens or "smart cards" are acceptable for identification. Out-of-band tokens involve local control of the token databases with the local authenticated server vouching for specific local users.

8. REQUIREMENTS AND AUDITS

Each organization that uses the Internet to transmit CMS Privacy Act-protected and/or other sensitive CMS information will be expected to meet the stated requirements set forth in this document.

All organizations subject to OMB Circular A-130 are required to have a Security Plan. All such organizations must modify their Security Plan to detail the methodologies and protective measures if they decide to use the Internet for transmittal of CMS Privacy Act-protected and/or other sensitive CMS information, and to adequately test implemented measures.

CMS reserves the right to audit any organization's implementation of, and/or adherence to the requirements, as stated in this policy. This includes the right to require that any organization utilizing the Internet for transmission of CMS Privacy Act-protected and/or other sensitive information submit documentation to demonstrate that they meet these requirements.

9. ACKNOWLEDGMENT OF INTENT

Organizations desiring to use the Internet for transmittal of CMS Privacy Act-protected and/or other sensitive CMS information must notify CMS of this intent. An e-mail address is provided below to be used for this acknowledgment. An acknowledgment must include the following information:
Name of Organization
Address of Organization
Type/Nature of Information being transmitted
Name of Contact (e.g., CIO or an accountable official)
Contact's telephone number and e-mail address
For submission of acknowledgment of intent, send an e-mail to: internetsecurity@CMS.gov. Internal CMS elements must proceed through the usual CMS system and project development process.

10. POINT OF CONTACT
For questions or comment, write to:

Office of Information Services, CMS
Security and Standards Group
Division of CMS Enterprise Standards -Internet
7500 Security Boulevard
Baltimore, MD 21244

Also, check out the Security Policy FAQs
Return to Information Clearinghouse Listing

Last Updated January 31, 2001

7.0 Standard Data Values

Contents

This section contains tables that identify the standard coding structures for several of the encounter data fields.

Use of Standard Data Values

The tables list all of the standard data values for the fields, with descriptions.

Standard data values are given for the following tables:

Table A	Admit Type (UB)
Table B	Admit Source (UB)
Table C	Place of Service (CMS 1500)
Table D	Place of Service (from UB Type of Bill)
Table E	Discharge Status (UB Patient Status)
Table G	Servicing Provider Type
Table H	Servicing Provider Specialty (CMS 1500)
Table I	Service Category I-A: MCO I-B: SCO I-C: One Care (ICO)
Table K	Bill Classifications – (UB Bill Classification, 3rd digit)
Table M	Present on Admission (UB)
Table N	Submission Clarification Code

Note: The abbreviation **NEC** after a description stands for **Not Elsewhere Classified**.

TABLE A
Type of Admission (UB)

Value	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6-8	Reserved for National Assignment
9	Information not available

TABLE B
Source of Admission (UB)

Value	Description
1	Physician Referral
2	Clinic/Outpatient Referral
3	HMO Referral
4	Transfer from Hospital
5	Transfer from SNF
6	Transfer from another Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	RESERVED FOR ASSIGNMENT BY THE NUBC (END 10/1/07)
B	TRANSFER FROM ANOTHER HOME HEALTH AGENCY
C	RESERVED FOR ASSIGNMENT BY THE NUBC (END 7/1/10)
D	TRANSFER FROM ONE UNIT TO ANOTHER - SAME HOSP
E	TRANSFER FROM AMBULATORY SURGICAL CENTER
F	TRANSFER FROM HOSPICE/ENROLLED IN HOSPICE PROGRAM

For Newborns

Value	Description
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

TABLE C
Place of Service (HCFA 1500)
Last updated November 1, 2009

Value	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (effective 10/1/05)
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison-Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)

Value	Place of Service Name	Place of Service Description
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

Value	Place of Service Name	Place of Service Description
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A

Value	Place of Service Name	Place of Service Description
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

* Revised, effective April 1, 2004.
** Revised, effective October 1, 2005

TABLE D
Place of Service (from UB Bill Type – 1st & 2nd digits)

Type of Facility (1st digit)

Value	Description
1	Hospital
2	Skilled Nursing Facility (SNF)
3	Home Health Agency (HHA)
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic (refer to *Clinics Only* for 2nd digit)
8	Substance Abuse or Specialty Facility
9	Halfway House

Bill Classifications – Facilities (2nd digit)

Value	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other
5	Basic Care
6	Complementary Inpatient
7	Complementary Outpatient
8	Swing Beds
9	Halfway House

Bill Classifications – Clinics only (2nd digit)

Value	Description
1	Rural Health Clinic
2	Hospital-based or Freestanding End State Renal Dialysis Facility
3	Freestanding Clinic
4	Other Rehab Facility (ORF) or Community Mental Health Center
5	Comprehensive Outpatient Rehab Facility (CORF)
6-8	Reserved for national assignment
9	Other

TABLE D (cont'd)

Place of Service (from UB Bill Type – 1st & 2nd digits)

Bill Classifications – Specialty Facility (2nd digit)

Value	Description
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
5	Critical Access Hospital
6	Residential Facility
7-8	Reserved for national assignment
9	Other

TABLE E
Discharge Status (UB Patient Status)

Value	Description
01	Discharged alive to home / self-care (routine discharge)
02	Discharged/Transferred to short term general hospital
03	Discharged/Transferred to skilled nursing facility (SNF)
04	Discharged/Transferred to intermediate care facility (ICF)
05	Discharged/Transferred to other facility
06	Discharged/Transferred to home care
07	Left against medical advice
08	Discharged/Transferred to home under care of a home IV drug therapy provider
09	Admitted as an inpatient to this hospital
10 – 19	Discharged to be defined at State level if necessary
20	Expired (Did not recover – Christian Science Patient)
21 – 29	Expired to be defined at State level if necessary
30	Still a patient
31 – 39	Still a patient to be defined at State level if necessary
40	Expired at home (Hospice claims only)
41	Died in a medical facility (Hospice claims only)
42	Place of death unknown (Hospice claims only)
43 – 99	Reserved for National Assignment

TABLE G
Servicing Provider Type

Value	Description
00	Placeholder PCP
01	Acute Care Hospital-Inpatient
02	Acute Care Hospital-Outpatient
03	Chronic Hospital-Inpatient
04	Chronic Hospital-Outpatient
05	Ambulatory Surgery Centers
06	Trauma Center
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep. (NEC)
21	Mental Health Facilities
22	Chemical Dependency Treatment Ctr.
23	Mental Health/Chem Dep Day Care
25	Rehabilitation Facilities
30	Long-Term Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Cont. Care Retirement Community
37	Day/Night Care Center
38	Hospice
40	Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
50	Physician
51	Medical Doctor MD
52	Osteopath DO
53	Allergy & Immunology
54	Anesthesiology
55	Colon & Rectal Surgery
56	Dermatology
57	Emergency Medicine
58	Family Practice
59	Geriatric Medicine
60	Internist (NEC)
61	Cardiovascular Diseases
62	Critical Care Medicine

TABLE G
Servicing Provider Type (cont'd)

Value	Description
63	Endocrinology/Metabolism
64	Gastroenterology
65	Hematology
66	Infectious Disease
67	Medical Oncology
68	Nephrology
69	Pulmonary Disease
70	Rheumatology
71	Neurological Surgery
72	Nuclear Medicine
73	Obstetrics/Gynecology
74	Ophthalmology
75	Orthopedic Surgery
76	Otolaryngology
77	Pathology
78	Pediatrician (NEC)
79	Pediatric Specialist
80	Physical Medicine and Rehabilitation
81	Plastic Surgery/Maxillofacial Surgery
82	Preventative Medicine
83	Psychiatry/Neurology
84	Radiology
85	Surgeon
86	Surgical Specialist
87	Thoracic Surgery
88	Urology
95	Dentist
96	Dental Specialist
99	Podiatry
100	Unknown Clinic
120	Chiropractor
125	Dental Health Specialists
130	Dietitian
135	Medical Technologists
140	Midwife
145	Nurse Practitioner
146	Nursing Services
150	Optometrist
155	Pharmacist
160	Physician's Assistant

TABLE G
Servicing Provider Type (cont'd)

Value	Description
165	Therapy (physical)
170	Therapists (supportive)
171	Psychologist
175	Therapists (alternative)
180	Acupuncturist
185	Spiritual Healers
190	Health Educator
200	Transportation
205	Health Resort
210	Hearing Labs
215	Home Health Organization
220	Imaging Center
225	Laboratory
230	Pharmacy
235	Supply Center
240	Vision Center
245	Public Health Agency
246	Rehab Hospital-Inpatient
247	Rehab Hospital-Outpatient
248	Psychiatric Hospital-Inpatient
249	Psychiatric Hospital-Outpatient
250	Community Health Center
301	General Hospital
302	Certified Clinical Nurse Specialist
303	Infusion Therapy
304	Palliative Care Medicine
305	Adult Day Health
306	Adult Foster Care / Group Adult Foster Care
307	Fiscal Intermediary Services (FIS)
308	Personal Care Management Agency
309	Independent Living Centers
310	Day Habilitation
311	Durable Medical Equipment
312	Oxygen And Respiratory Therapy Equip
313	Prosthetics
314	Orthotics
315	Renal Dialysis Clinics
316	Respite Care
317	Intensive Residential Treatment Program (IRTP)
318	Complex Care Management
319	Special Programs
320	Recovery Learning Community (RLCs)
321	Certified Peer Specialist
322	Emergency Services Program (ESP)
323	Community Health Worker
324	Hospital Licensed Health Center

TABLE G
Servicing Provider Type (cont'd)

Value	Description
325	Aging Services Access Point (ASAP)
326	Geriatric Mental Health
327	Child Mental Health
328	Deaf and Hard of Hearing Independent Living Services Programs
329	Home Modification Service Providers
330	Transitional Assistance (across settings) Providers
331	Medication Management Providers
332	Substance Abuse Treatment Center
333	Magnetic Resonance Centers
334	Psych Day Treatment
335	QMB (Qualified Medicare Beneficiaries) Only Provider
336	Group Practice Physicians
337	School-Based Clinic or Health Center
338	Billing Agent

TABLE H
Servicing Provider Specialty (from CMS 1500)

Value	Description
01	General Practice
02	General Surgery
03	Allergy / Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologists
16	Obstetrics / Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (Dentists Only)
20	Orthopedic Surgery
22	Pathology
23	Sports Medicine
24	Plastic & Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
30	Diagnostic Radiology
31	Intensive Cardiac Rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery

TABLE H
Servicing Provider Specialty (cont'd)

Value	Description
41	Optometrist
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Diseases
45	Mammography Screening Center
46	Endocrinology
48	Podiatrist
49	Ambulatory Surgery Center
50	Nurse Practitioner
51	Med Supply Co w/Certified Orthotist
52	Med Supply Co w/Certified Prosthetist
53	Med Supply Co w/Certified Prosthetist/Orthotist
54	Med Supply Co not included in 51, 52 or 53
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Prosthetist/Orthotist
58	Individuals not included in 55, 56 or 57
59	Ambulance Service Supplier
60	Public Health or Welfare Agency (Federal, State & Local Govt)
61	Voluntary Health Agency (ex: Planned Parenthood)
62	Psychologist
63	Portable X-Ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapist
68	Clinical Psychologist
69	Clinical Laboratory
70	Multispecialty Clinic or Group Practice
71	Registered Dietician/Nutrition Professional
72	Pain Management
73	Mass Immunization Roster Biller
74	Radiation Therapy Centers
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine

TABLE H
Servicing Provider Specialty (cont'd)

Value	Description
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers (i.e. Drug, & Department Stores)
88	Unknown Supplier/Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Independent Physiological Lab
96	Optician
97	Physician Assistant
98	Gynecologist/Oncologist
99	Unknown Physician Specialty
A0	Hospital
A1	SNF
A2	Intermediate Care Facility
A3	Nursing Facility, Other
A4	HHA
A5	Pharmacy
A6	Medical Supply Co w/Respiratory Therapist
A7	Department Store
A8	Grocery Store
A9	Dentist
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency
B5	Ocularist

TABLE I – A
Service Category (Using the 4B reporting groups)

Value	Description
1	Capitated Physician Services
2	Fee For Service Physician Services
3	Behavioral Health –Inpatient Services
4	Behavioral Health –Diversionary Services *
5	Behavioral Health –Emergency Services Program (ESP) Services
6	Behavioral Health –Mental Health Outpatient Services *
7	Behavioral Health –Substance Abuse Outpatient Services *
8	Behavioral Health –Other Outpatient Services *
9	Facility- Medical/Surgical
10	Facility- Pediatric/Sick Newborns
11	Facility- Obstetrics
12	Facility- Skilled Nursing Facility/Rehab
13	Facility- Other Inpatient
14	Facility- Emergency Room
15	Facility –Ambulatory Care
16	Prescription Drug
17	Laboratory
18	Radiology
19	Home Health
20	Durable Medical Equipment
21	Emergency Transportation
22	Therapies
23	Other (Please use this for Vision and Dental claims)
24	Other Alternative Care
25	Mental Health and Substance Abuse Outpatient Services(MBHP Only)*
26	Outpatient Day Services (MBHP Only) *
27	Non-ESP Emergency Services (MBHP Only) *
28	Behavioral Health –Diversionary Services – 24-Hour
29	Behavioral Health – Diversionary Services – Non-24-Hour
30	Behavioral Health –Standard Outpatient Services
31	Behavioral Health –Other Services
32	Behavioral Health – Intensive Home or Community Based Outpatient Services for Youth (Please note this new category is where all CBHI services, except youth mobile crisis intervention would be listed. Youth mobile crisis intervention would be considered part of the Emergency Services Program Services.)

*** Use these categories *only* for those claims with Dates of Service before 07/01/2010,**

TABLE I – B1

Service Category (Using the SCO reporting groups)

Note: Claims with Date of Service **on or after October 1, 2016** should be submitted with the service categories in Table I-B1.

Value	Description
301	Hospital Inpatient
302	Behavioral Health (BH) Hospital Inpatient
303	Hospital Outpatient
304	Behavioral Health (BH) Hospital Outpatient
305	Professional
306	Vision
307	Dental
308	Therapy
309	Pharmacy/Drugs
310	Laboratory, Radiology, Testing
311	Institutional Long Term Care
312	Community Long Term Care
313	Home and Community Based Waiver
314	Transportation
315	Medical Equipment
316	Hospice
317	Case Management
318	Other Miscellaneous

TABLE I – B2

Service Category (Using the SCO reporting groups)

Note: Claims with Date of Service **before October 1, 2016** should be submitted with the old service categories in Table I-B2.

Value	Description
101	Acute Inpatient
102	Chronic Inpatient
103	Outpatient Clinic
104	Mental Health/Substance Abuse
105	Physicians
106	Nonphysician Practitioners
107	Vision Care
108	Dental Care
109	Therapies
110	Pharmacy
111	Laboratory, radiology, testing
112	Institutional Long Term Care
113	Community Long Term Care
114	Waiver Services
115	Transportation
116	Supplies/ Durable Medical Equipment
117	Hospice
118	Care Management
119	Miscellaneous

TABLE I – C
Service Category (Using the One Care - ICO reporting groups)

Value	Description
201	Acute Inpatient
202	Inpatient – MH/SA
203	Hospital Outpatient
204	Outpatient – MH/SA
205	Professional
210	Pharmacy
212	Pong-Term Care (LTC) Facility
213	Homer and Community Based Services (HCBS)/Home Health
215	Transportation
216	Durable Medical Equipment (DME) and Supplies
217	*All Other

*Should follow the definition in the “Quarterly Financial Report” submitted to EOHHS Budget Unit

TABLE K
Bill Classifications - Frequency (3rd digit)

Value	Description
0	Nonpayment/Zero Claims
1	Admit thru discharge claim
2	Interim-first claim
3	Interim –continuing claim
4	Interim-last claim
5	Late charges only claim
6	Adjustment of prior claim
7	Replacement of prior claim
8	Void/back out of prior claim
9	Final claim for Home Health PPS episode
A	Admission/Election Notice
B	Hospice termination revocation notice
C	Hospice change of provider notice
D	Hospice Void/back out
E	Hospice change of ownership
F	Beneficiary Initiated adjustment claim-other
G	CWF Initiated adjustment claim-other
H	CMS Initiated adjustment claim-other
I	Intermediary adjustment claim (other than PRO or Provider)
J	Initiated adjustment claim-other
K	OIG initiated adjustment claim
L	Reserved for national assignment
M	MSP initiated adjustment claim
N	PRO adjustment Claim
O	Nonpayment/Zero Claims
P-W	Reserved for national assignment
X	Void/back out a prior abbreviated encounter submission
Y	Replacement of a prior abbreviated encounter submission
Z	New abbreviated encounter submission

TABLE M
Present on Admission (UB)

Value	Definition
Y	Yes, present at the time of IP admission
N	No, not present at the time of IP admission
U	No information in the record. Documentation is insufficient to determine if condition is POA
W	Clinically undetermined. Provider is unable to clinically determine whether condition was POA or not
Blank	Exempt from POA reporting. Leave blank if condition is on the “not applicable” list ;

TABLE N
Submission Clarification Code

CODE	DESCRIPTION	VALUE LIMITATIONS
1	No Override	
2	Other Override	
3	Vacation supply – the pharmacist id indicating that the cardholder has requested a vacation supply of the medicine	
4	Lost Prescription - the pharmacist indicates that the cardholder has requested a replacement of medication that has been lost	
5	Therapy Change - the pharmacist is indicating that the physician has determined that a change in therapy was required ; either that the medication was used faster than expected, or a different dosage form is needed, etc.	
6	Starter dose – the pharmacist is indicating that the previous medication was a started dose and now additional medication is needed to continue treatment.	
7	Medically Necessary - the pharmacist is indicating that this medication has been determined by physician to be medically necessary.	
8	Process Compound for Approved Ingredients.	
9	Encounters.	
10	Meets Plan Limitations – the pharmacy certifies that the transaction is in compliance with the program ‘s policies and rules that are specific to the particular product being billed.	
11	Certification on File – the supplier’s guarantee that a copy of the paper certification, signed and dated by the physician, is on file at the supplier’s office.	
12	DME replacement Indicator - indicator that this certification is for a DME item replacing a previously purchased DME item.	
13	Payer-Recognized Emergency/Disaster Assistance request - the pharmacist is indicating that an override is needed based on an emergency / disaster situation recognized by the payer.	
14	Long Term Care Leave of Absence - the pharmacist is indicating that the cardholder requires a short-fill of a prescription due to a leave of absence from the Long Term Care (LRC) facility.	
15	Long Term Care replacement Medication – Medication has been contaminated during administration in a Long Term Care setting.	
16	Long Term Care emergency box (kit) or automated dispensing machine – indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours.	
17	Long Term Care Emergency supply reminder – indicates that the transaction is for the remainder of the drug originally begun from an Emergency kit.	
18	Long term Care patient Admit/readmit Indicator – Indicates that the transaction is for a new dispensing of medication due to the patient’s admission or readmission status	
19	Split billing – Indicates the quantity dispensed in the reminder billed to a subsequent payer when Medicare Part A expires. Used only in Long Term Care settings.	
20	**340B – Indicates that prior to providing service, the pharmacy has determined the product being bellied is purchased pursuant to rights available under Section 340B of the Public Health Act of 1992 including sub-selling purchases authorized by Section 340B of (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8)**	
21	LTC dispensing: 14 days or less not applicable – fourteen day or less dispensing ins not applicable due to CMS exclusion and / or manufacturer packaging may not be broken or special dispensing methodology (i.e. vacation supply, leave of absence, ebox, splitter dose). Medication quantities are dispensed as billed.	Telecom. ECL Emergency Implementation Dt. Is July 1, 2012.

22	LTC dispensing: 7 days - Pharmacy dispenses medication in 7 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
23	LTC dispensing: 4 days - Pharmacy dispenses medication in 4 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
24	LTC dispensing: 3 days - Pharmacy dispenses medication in 3 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
25	LTC dispensing: 2 days - Pharmacy dispenses medication in 2 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
26	LTC dispensing: 1 day - Pharmacy or remote (multiple shifts) dispenses medication in 1 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
27	LTC dispensing: 4-3days - Pharmacy dispenses medication in 4 day , then 3 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
28	LTC dispensing: 2-2-3days - Pharmacy dispenses medication in 2 day , then 2 day , then 3 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
29	LTC dispensing; daily and 3 day weekend – pharmacy or remote dispensed daily during the week and combines multiple days dispensing for weekends.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
30	LTC dispensing: Per shift dispensing - remote dispensing per shift (multiple meds passes).	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
31	LTC dispensing: Per med pass dispensing – remote dispensing per med pass.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
32	LTC dispensing: PRN on demand – remote dispensing on demand as needed.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
33	LTC dispensing: 7 days or less cycle not otherwise represented.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
34	LTC dispensing: 14 days dispensing – pharmacy dispenses medications in 14 day supplies.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
35	LTC dispensing: 8-14 days dispensing method not listed above – 8-14-Day dispensing cycle not otherwise represented.	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.
36	LTC dispensing: dispensed outside short cycle - Claim was originally	Telecom. ECL Emergency Implementation Dt. Is July 1,2012.

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- Correct layout format
- Fields are correct in size and type of data (alpha vs. numeric)
- Missing fields
- Accurate data type (only usual characters are permitted)
- Reasonability of data
- ***ICD Version Qualifier*** (field # 193) is populated on every encounter claim record that has either ICD diagnosis codes or ICD procedure codes.
- All ICD diagnosis and ICD procedure codes on a claim record are consistent with ICD Version Qualifier.

Data Quality

- Each field is checked for both quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports
- Reasonability reports

#	Field Name	MassHealth Standard
1	Org. Code	100% present
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Entity PIDSL	100% present on ACO encounters
4	Record Indicator	100% present
5	Claim Number	100% present
6	Claim Suffix	100% present
7	Pricing Indicator	Directions will be provided later, validation standards TBD
8	Recipient DOB	100% present and valid, as compared to encounter service dates
9	Recipient Gender	100% present and valid, as found in Data Elements table
10	Recipient ZIP Code	100% present
11	Medicare Code	Provide if applicable
12	Other Insurance Code	100% present and valid, as found in Data Elements table
13	Submission Clarification Code	Provide if available on Pharmacy claims only
14	Claim Type	100% present and valid for MBHP only

#	Field Name	MassHealth Standard
15	Admission Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
16	Discharge Date	100% present and valid value on all Hospital discharges and Long Term Care discharges.
17	From Service Date	100% present and valid date on all claims; dates should be evenly distributed across time
18	To Service Date	100% present and valid date on all claims.
19	Primary Diagnosis	100% present and valid ICD codes on - all Professional, Institutional (including Long Term Care) , Vision, and Transportation claims. On Transportation claims for the services like “a ride to the grocery store”, MCEs should use generic diagnosis codes such as: V46.3 – Wheelchair dependence; V49.9 – Unspecified problem with limbs and other problems; V58.9 – Unspecified aftercare. Should be submitted on Dental claims when available. Not required on Pharmacy claims. E-codes not valid as primary diagnosis. Consistent with ICD Version Qualifier.
20	Secondary Diagnosis	60% present and valid ICD codes on inpatient facility and 20% present and valid on other records, excluding drug and vision. Not routinely coded on Dental records and LTC. Consistent with ICD Version Qualifier.
21	Tertiary Diagnosis	Provide if available. Consistent with ICD Version Qualifier.
22	Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
23	Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
24	Type of Admission	100% present and valid value *(Admit Type, Table A) on all inpatient claims,* Long Term Care claims, and all hospital (institutional) claims with admission.
25	Source of Admission	100% present and valid value (*Admit Source, Table B*) *on all inpatient claims,* Long Term Care claims, and all hospital (institutional) claims with admission.
26	Procedure Code	98% present and valid in general but should be 100% present on all professional claims .Procedure Code Indicator match (i.e., if the code is a “CPT or HCPCS Level 1 Code” then the Procedure code indicator should be “2”).
27	Procedure Modifier 1	Provide if available

28	Procedure Modifier 2	Provide if available
29	Procedure Modifier 3	Provide if available
30	Procedure Code Indicator	100% present and valid if Procedure Code field is filled
31	Revenue Code	98% present and valid on Hospital and Long Term Care claims only and should be 100% present on all Inpatient claim detail lines
32	Place of Service	100% present and valid value *on all hospital (institutional), Long Term Care, and professional claims.*
33	Type Of Bill	100% present and valid on all Institutional and Professional claims
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, Long term Care claims, and all hospital (institutional) claims with admission.
35	FILLER	
36	Quantity	100% present on all claim categories.
37	NDC Number	98% present and valid values, on Pharmacy claims; and on Hospital and Professional claims when applicable
38	Metric Quantity	100% present and valid values, only on Pharmacy claims, reasonability of values (total number of units or volume) and on Hospital and Professional claims when applicable.
39	Days Supply	100% present and valid values, only on all prescription drug Pharmacy claims.
40	Refill Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
41	Dispense As Written Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
42	Dental Quadrant	100% present and valid values (1-4), only on dental claims , where applicable
43	Tooth Number	100% present, only on dental claims, where applicable
44	Tooth Surface	100% present, only on dental claims, where applicable
45	Paid Date	100% present and valid date, falls within submitted date range, falls after “Admit, Discharge, To, and From Dates”
46	Service Class	100% present and valid for MBHP only
47	PCP Provider ID	100% present should be an enrolled provider listed in provider enrollment file. Not applicable to MBHP.
48	PCP Provider ID Type	100% present and valid based on PCP Provider ID field. Not applicable to MBHP.
49	PCC Internal Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
50	Servicing Provider ID	100% present and valid on all claims except Pharmacy. Should be an enrolled provider listed in provider enrollment file.
#	**Field Name**	**MassHealth Standard**
51	Servicing Provider ID Type	100% present and valid on all claims except Pharmacy, Based on Servicing Provider ID field

52	Referring Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
53	Referring Provider ID Type	100% present and valid, only when Referring Provider ID is present
54	Servicing Provider Class	100% present and valid on all records, as found in the Data Elements table.
55	Servicing Provider Type	100% present and valid value (*Servicing Provider Type, Table G*)
56	Servicing Provider Specialty	100% present and valid value (*Servicing Provider Specialty, Table H*)
57	Servicing Provider ZIP Code	100% present and valid
58	Billing Provider ID	100% present and valid on all claims; should be an enrolled provider listed in provider enrollment file.
59	Authorization Type	100% present and valid for MBHP only
60	Billed Charge	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
61	Gross Payment Amount	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
62	TPL Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
63	Medicare Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
64	Copay/Coinsurance	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
65	Deductible	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
66	Ingredient Cost	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
67	Dispensing Fee	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
68	Net Payment	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts

#	Field Name	MassHealth Standard
69	Withhold Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
70	Record Type	100% present and valid on all records, as found in the Data Elements table, dollar amount checks
71	Group Number	100% present and valid
72	DRG	100% present and valid value (001 - 495), on Acute Inpatient Hospital claims, when collected by plan.
73	EPSDT Indicator	Not coded at the present time
74	Family Planning Indicator	Not coded at the present time
75	MSS/IS	Not coded at the present time
76	New Member ID (consistent with above data)	100% Present and valid on all claims; not allowed to be missed or invalid.
77	Former Claim Number	100% present and valid, only when Record Type is not O
78	Former Claim Suffix	100% present and valid, only when Record Type is not O
79	Record Creation Date	100% present and valid date
80	Service Category	100% present and valid (*Service Category, Table I*)
81	Prescribing Prov. ID	100% present and valid on Pharmacy claims. Should be an enrolled provider listed in provider enrollment file.
82	Date Script Written	100% present and valid on Pharmacy claims.
83	Compound Indicator	100% present and valid on prescription drug records
84	Rebate Indicator	100% present and valid on prescription drug records
85	Admitting Diagnosis	100% present and valid value on all Inpatient claims, Long Term Care claims, and all hospital (institutional) claim with admission.
86	Allowable Amount	100% present and valid, financial field with implied 2 decimals, mathematical check with other dollar amounts
87	Attending Prov. ID	100% present should be an enrolled provider listed in provider enrollment file. Inpatient Claims only.
88	Non-covered Days	Provide if applicable
89	External Injury Diagnosis 1	Provide if available. Consistent with ICD Version Qualifier.
90	Claim Received Date	100% present and valid date
91	Frequency	100% present and valid on Inpatient claims.

#	Field Name	MassHealth Standard
92	**PCC Internal Provider ID Type**	100% present and valid, when PCC Provider ID is present
93	Billing Provider ID _Type	100% present, and valid on all claims.
94	Prescribing Prov. ID _Type	100% present and valid on Pharmacy claims.
95	Attending Prov. ID _Type	100% present, and valid
96	Admission Time	100% present and valid value on Hospital and Long Term Care claims
97	Discharge Time	100% present and valid value on Hospital and Long Term Care claims
98	Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
99	Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
100	Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
101	Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
102	Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
103	Surgical Procedure code 1	Provide if available. Consistent with ICD Version Qualifier.
104	Surgical Procedure code 2	Provide if available. Consistent with ICD Version Qualifier.
105	Surgical Procedure code 3	Provide if available. Consistent with ICD Version Qualifier.
106	Surgical Procedure code 4	Provide if available. Consistent with ICD Version Qualifier.
107	Surgical Procedure code 5	Provide if available. Consistent with ICD Version Qualifier.
108	Surgical Procedure code 6	Provide if available. Consistent with ICD Version Qualifier.
109	Surgical Procedure code 7	Provide if available. Consistent with ICD Version Qualifier.
110	Surgical Procedure code 8	Provide if available. Consistent with ICD Version Qualifier.
111	Surgical Procedure code 9	Provide if available. Consistent with ICD Version Qualifier.
112	Employment	Provide if available
113	Auto Accident	Provide if available
114	Other Accident	Provide if available
115	Total Charges	Provide if available
116	Non Covered charges	Provide if available
117	Coinsurance	Provide if available
118	Void Reason Code	Provide if available
119	DRG Description	Provide if applicable
120	DRG Type	Provide if applicable
121	DRG Version	Provide if applicable
122	DRG Severity of Illness Level	Provide if applicable
123	DRG Risk of Mortality Level	Provide if applicable
124	Patient Pay Amount	Provide if applicable
125	Patient Reason for Visit Diagnosis 1	Provide if applicable. Consistent with ICD Version Qualifier.
126	Patient Reason for Visit Diagnosis 2	Provide if applicable. Consistent with ICD Version Qualifier.
127	Patient Reason for Visit Diagnosis 3	Provide if applicable. Consistent with ICD Version Qualifier.
128	Present on Admission (POA) 1	100% present on Hospital and Long Term Care claims
129	Present on Admission (POA) 2	Provide if Diagnosis 2 is available on Hospital and Long Term Care claims
130	Present on Admission (POA) 3	Provide if Diagnosis 3 is available on Hospital and Long Term Care claims
131	Present on Admission (POA) 4	Provide if Diagnosis 4 is available on Hospital and Long Term Care claims

#	Field Name	MassHealth Standard
132	Present on Admission (POA) 5	Provide if Diagnosis 5 is available on Hospital and Long Term Care claims
133	Present on Admission (POA) 6	Provide if Diagnosis 6 is available on Hospital and Long Term Care claims
134	Present on Admission (POA) 7	Provide if Diagnosis 7 is available on Hospital and Long Term Care claims
135	Present on Admission (POA) 8	Provide if Diagnosis 8 is available on Hospital and Long Term Care claims
136	Present on Admission (POA) 9	Provide if Diagnosis 9 is available on Hospital and Long Term Care claims
137	Present on Admission (POA) 10	Provide if Diagnosis 10 is available on Hospital and Long Term Care claims
138	Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
139	Present on Admission (POA) 11	Provide if Diagnosis 11 is available on Hospital and Long Term Care claims
140	Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
141	Present on Admission (POA) 12	Provide if Diagnosis 12 is available on Hospital and Long Term Care claims
142	Diagnosis 13	Provide if available. Consistent with ICD Version Qualifier.
143	Present on Admission (POA) 13	Provide if Diagnosis 13 is available on Hospital and Long Term Care claims
144	Diagnosis 14	Provide if available. Consistent with ICD Version Qualifier.
145	Present on Admission (POA) 14	Provide if Diagnosis 14 is available on Hospital and Long Term Care claims
146	Diagnosis 15	Provide if available. Consistent with ICD Version Qualifier.
147	Present on Admission (POA) 15	Provide if Diagnosis 15 is available on Hospital and Long Term Care claims
148	Diagnosis 16	Provide if available. Consistent with ICD Version Qualifier.
149	Present on Admission (POA) 16	Provide if Diagnosis 16 is available on Hospital and Long Term Care claims
150	Diagnosis 17	Provide if available. Consistent with ICD Version Qualifier.
151	Present on Admission (POA) 17	Provide if Diagnosis 17 is available on Hospital and Long Term Care claims
152	Diagnosis 18	Provide if available. Consistent with ICD Version Qualifier.
153	Present on Admission (POA) 18	Provide if Diagnosis 18 is available on Hospital and Long Term Care claims
154	Diagnosis 19	Provide if available. Consistent with ICD Version Qualifier.
155	Present on Admission (POA) 19	Provide if Diagnosis 19 is available on Hospital and Long Term Care claims
156	Diagnosis 20	Provide if available. Consistent with ICD Version Qualifier.
157	Present on Admission (POA) 20	Provide if Diagnosis 20 is available on Hospital and Long Term Care claims
158	Diagnosis 21	Provide if available. Consistent with ICD Version Qualifier.
159	Present on Admission (POA) 21	Provide if Diagnosis 21 is available on Hospital and Long Term Care claims
160	Diagnosis 22	Provide if available. Consistent with ICD Version Qualifier.
161	Present on Admission (POA) 22	Provide if Diagnosis 22 is available on Hospital and Long Term Care claims
162	Diagnosis 23	Provide if available. Consistent with ICD Version Qualifier.
163	Present on Admission (POA) 23	Provide if Diagnosis 23 is available on Hospital and Long Term Care claims
164	Diagnosis 24	Provide if available. Consistent with ICD Version Qualifier.

#	Field Name	MassHealth Standard
165	Present on Admission (POA) 24	Provide if Diagnosis 24 is available on Hospital and Long Term Care claims
166	Diagnosis 25	Provide if available. Consistent with ICD Version Qualifier.
167	Present on Admission (POA) 25	Provide if Diagnosis 25 is available on Hospital and Long Term Care claims
168	Diagnosis 26	Provide if available. Consistent with ICD Version Qualifier.
169	Present on Admission (POA) 26	Provide if Diagnosis 26 is available on Hospital and Long Term Care claims
170	Present on Admission (POA) EI 1	Provide if External Injury Diagnosis 1 is available on Hospital and Long Term Care claims
171	External Injury Diagnosis 2	Provide if available. Consistent with ICD Version Qualifier.
172	Present on Admission (POA) EI 2	Provide if External Injury Diagnosis 2 is available on Hospital and Long Term Care claims
173	External Injury Diagnosis 3	Provide if available. Consistent with ICD Version Qualifier.
174	Present on Admission (POA) EI 3	Provide if External Injury Diagnosis 3 is available on Hospital and Long Term Care claims
175	External Injury Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
176	Present on Admission (POA) EI 4	Provide if External Injury Diagnosis 4 is available on Hospital and Long Term Care claims
177	External Injury Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
178	Present on Admission (POA) EI 5	Provide if External Injury Diagnosis 5 is available on Hospital and Long Term Care claims
179	External Injury Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
180	Present on Admission (POA) EI 6	Provide if External Injury Diagnosis 6 is available on Hospital and Long Term Care claims
181	External Injury Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
182	Present on Admission (POA) EI 7	Provide if External Injury Diagnosis 7 is available on Hospital and Long Term Care claims
183	External Injury Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
184	Present on Admission (POA) EI 8	Provide if External Injury Diagnosis 8 is available on Hospital and Long Term Care claims
185	External Injury Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
186	Present on Admission (POA) EI 9	Provide if External Injury Diagnosis 9 is available on Hospital and Long Term Care claims
187	External Injury Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
188	Present on Admission (POA) EI 10	Provide if External Injury Diagnosis 10 is available on Hospital and Long Term Care claims
189	External Injury Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
190	Present on Admission (POA) EI 11	Provide if External Injury Diagnosis 11 is available on Hospital and Long Term Care claims
191	External Injury Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
192	Present on Admission (POA) EI 12	Provide if External Injury Diagnosis 12 is available on Hospital and Long Term Care claims
193	ICD Version Qualifier	100 % Present on all Professional and Institutional claims. 100% required on all other claims when at least one ICD diagnosis code or ICD surgical procedure code is submitted..
194	Procedure Modifier 4	Provide if available
195	Service Category Type	100% present and valid
196	Ambulance Patient Count	Provide if applicable
197	Obstetric Unit Anesthesia Count	Provide if applicable
198	Prescription Number	100% present on Pharmacy claims
199	Taxonomy Code	Provide if available

#	Field Name	MassHealth Standard
200	Rate Increase Indicator	Provide if applicable
201	Bundle Indicator	100% present on bundled claims
202	Bundle Claim Number	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
203	Bundle Claim Suffix	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
204	Value Code	Provide on the new-born claim lines
205	Value Amount	Provide when Value Code is present in field # 203
206	Surgical Procedure Code 10	Provide if available. Consistent with ICD Version Qualifier.
207	Surgical Procedure Code 11	Provide if available. Consistent with ICD Version Qualifier.
208	Surgical Procedure Code 12	Provide if available. Consistent with ICD Version Qualifier.
209	Surgical Procedure Code 13	Provide if available. Consistent with ICD Version Qualifier.
210	Surgical Procedure Code 14	Provide if available. Consistent with ICD Version Qualifier.
211	Surgical Procedure Code 15	Provide if available. Consistent with ICD Version Qualifier.
212	Surgical Procedure Code 16	Provide if available. Consistent with ICD Version Qualifier.
213	Surgical Procedure Code 17	Provide if available. Consistent with ICD Version Qualifier.
214	Surgical Procedure Code 18	Provide if available. Consistent with ICD Version Qualifier.
215	Surgical Procedure Code 19	Provide if available. Consistent with ICD Version Qualifier.
216	Surgical Procedure Code 20	Provide if available. Consistent with ICD Version Qualifier.
217	Surgical Procedure Code 21	Provide if available. Consistent with ICD Version Qualifier.
218	Surgical Procedure Code 22	Provide if available. Consistent with ICD Version Qualifier.
219	Surgical Procedure Code 23	Provide if available. Consistent with ICD Version Qualifier.
220	Surgical Procedure Code 24	Provide if available. Consistent with ICD Version Qualifier.
221	Surgical Procedure Code 25	Provide if available. Consistent with ICD Version Qualifier.
222	Attending Prov. ID Address Location Code	Provide when Attending Prov. ID is present
223	Billing Provider ID Address Location Code	Provide when Billing Provider ID is present
224	Prescribing Prov. ID Address Location Code	Provide when Prescribing Prov. ID is present
225	PCP Provider ID Address Location Code	Provide when PCP Provider ID is present
226	Referring Provider ID Address Location Code	Provide when Referring Provider ID is present
227	Servicing Provider ID Address Location Code	Provide when Servicing Provider ID is present
228	PCC Provider ID Address Location Code	Provide when PCC Internal Provider ID is present

9.0 Appendices

Appendix C – *Member Enrollment File Specifications*

1. ***Overview:***

MCEs are required to submit member enrollment data on a monthly basis as part of the Encounter data submission. Member level enrollment data are needed to enhance reporting related to multiple EHS projects.
In particular, the updated Member Enrollment File is meant to capture member enrollment with a PCP and member demographics. In addition, MassHealth would like to start documenting information on Care Coordination and/or Care Management providers as a means to better understand this aspect of care delivery.

2. ***Technical Specifications:***

MCEs should submit a full refresh of the following three files on a monthly basis.

Member File

1. Each MCE should submit a full refresh of Member File of all MassHealth and CommCare members who have been enrolled with the MCE on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The Member File contains the **member** MassHealth ID and demographic information.
3. The Member File is a snapshot as of the end of the month prior to the submission date. For example, the "as of" date for data submitted end of September 2013 is August 31, 2013.
4. The Member File always contains the most current member demographic information.
5. Member records submitted by the MCEs stay in EHS DW unless the MCE sends a "delete" file with the member records that have to be removed from EHS DW system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.*** In this case, the member in the delete file will be deleted from both the Member File and the Member Enrollment File (See section 3 –Submission Process).

Member Enrollment File

1. Each MCE should submit a full refresh of all MassHealth and CommCare members who have been enrolled with a **PCP and/or CM Provider** (Care Coordinator, Care Coordination Program, Care Manager, or Care Management Program) on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The file should include ***all*** enrollments since 1/1/2010. For example, if a member had three PCP enrollments during this period then all three enrollments will be reported in the file.
3. Begin and End Enrollment dates must reflect changes in member ***enrollment*** with a PCP, CM Provider and changes in Practice affiliation.

4. Members who are enrolled with an MCE and are in the Member File, but do not have PCP or CM Provider enrollment should ***not*** be included in Member Enrollment file.
5. All members included in the Member Enrollment File should also be included in the Member File.
6. Any member enrollment record that existed in prior files and is not submitted in current files get "soft" deleted from MassHealth system.

A. Member Enrollment File Providers and Practices

1. Care Coordinators, Care Managers, Care Coordination and Management Programs are referred to as **CM Providers**.
2. PCPs and CM Providers are considered **"Providers**", and their IDs should be submitted in the Provider ID field.
3. The Practice that the above providers are associated with is referred to as "**Practice**", and the Practice Provider ID should be submitted in the Practice ID field.
4. If one Practice location cannot be identified for the member enrollment with a PCP then MCEs should provide the ID for the PCP's head contracting entity in the Practice ID field.
5. A "Provider Enroll Type" field indicates whether the Provider ID is for a PCP or a CM Provider.
6. A "Care Level" field indicates whether the **CM Provider IDs** are submitted **at the MCE or Practice/Provider level**.
7. If a member is enrolled with two types of providers (e.g. PCP and Care Manager), two records will be submitted with two different Provider Enroll Types for that member even if the PCP happens to be the same provider as the Care Manager.
8. MCEs would need to submit unique identifiers for the **CM Providers**. These unique identifiers must be maintained by the MCE and must be included in the **Care Management Provider File** (see below)
9. The only information required in the Member Enrollment File for a Provider and Practice is Provider ID/Provider ID Type and Practice ID/Practice ID Type.
10. Every Provider ID **for a PCP** and every Practice ID must exist in the Provider File submitted in the Encounter file.
11. Every Provider ID **for a CM Provider** must exist in the **Care Management Provider File** (see Care Management Provider File below)
12. Any change in ***Provider or Practice*** demographic information would ***not*** require the submission of any new records in the Member Enrollment File. Demographic information will be maintained in the Encounter Provider File or the Care Management Provider File.

B. Member Enrollment File Begin and End Enrollment Dates

1. The Member Enrollment File will have "Begin" and "End" Enrollment Dates to identify all enrollments with a PCP or CM Providers.
2. Any change in the member enrollment with a provider would require additional records with new "Begin" and "End" Enrollment dates.

3. "Begin" and "End" enrollment dates must be submitted with each record. End Enrollment Date for "active" enrollments with a provider will be submitted as "End of Time" (EOT – 99991231)

Care Management Provider File

1. MCE will submit a Care Management Provider File that includes all **CM Providers** (Care Coordinators, Care Managers, Care Coordination and Management Programs) ***who are not inlcuded in the Encounter Provider File.***
2. The Care Management Provider File will have "Effective" and "Term" dates for CM Providers that must be submitted with each record. Term Date for "active" records should be submitted as "End of Time" (EOT – 99991231)

3. Submission Process:

1. Member ZIP File must be named "MCE_MEMBER_YYYYMMDD.zip" (e.g. BMC_MEMBER_20130831.zip).
2. Member ZIP File must include Member File, Member Enrollment File, Care Management Provider File and Member Metadata File.
3. Member File, Member Enrollment File, and Care Management Provider File must be submitted as "Pipe" delimited text files.
4. The member metadata file in the Member ZIP File must be named MEM_metadata.txt.
5. Member ZIP File must be submitted at the same time the Encounter data is submitted.
6. Moving forward, the **Encounter** Zip File is required to be named **MCE_Claims_YYYYMMDD.zip** (e.g. BMC_Claims_20130930.zip). This the only change required in the current Encounter data submission process. Please use this naming convention for the encounter data file even when the member file is not sent. The Manual Override file should be named **MCE_Claims_YYYYMMDD**_MO**.zip**.
7. After the data transfer is complete, include a zero byte file called **mce_done.txt** for the Encounter Zip file and **mem_mce_done.txt** for the Member Zip file. The file "mem_mce_done.txt" is only needed when the Member Zip file is submitted.

Member Metadata File

Metadata Field	**Submission**
MCE_Id="Value"	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Member_File_Name="Value"	Mandatory
MemEnroll_File_Name="Value"	Mandatory
CareMgmt_File_Name="Value"	Mandatory
Total_Member_Records="Value"	Mandatory
Total_MemEnroll_Records="Value"	Mandatory
Total_CareMgmt_Records="Value"	Mandatory
Time_MemEnroll_From="Value" (YYYYMMDD)	Mandatory
Return_To="Email Address"	Mandatory

Notes:

i. Total_Member_Records is the total number of records in the Member File
ii. Total_MemEnroll_Records is the total number of records in the Member Enrollment File.
iii. Time_MemEnroll_From is the earliest "Begin" Enrollment Date in the Member Enrollment File.
iv. Total_CareMgmt_Records is the total number of records in the Care Management Provider File.
v. For files missing from a submission set corresponding field value to "none.txt"

Member Delete File

1. Member Delete File has the same format as Member File but will only have the member records that need to be deleted from our system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.***
2. The member in the delete file will be deleted from both the Member File and the Member Enrollment File.
3. Member Delete File will be submitted independently from the Member Zip file and will be named **MCE_DELETE_MEM_YYYYMMDD.txt** (e.g. BMC_DELETE_MEM_20130930.txt).
4. The Member Delete File can be submitted any time, however the MCE must send an email to MassHealth Data Warehouse to notify them about the submission of a delete file.

4. Validation Rules:

Member File

1. All Member IDs submitted in the Member File should exist in MMIS.
2. In the following scenarios, all records for that Member ID will be rejected:
    1. Member ID is missing
    2. Member ID is invalid
    3. Org. Code is missing
    4. Org. Code is not meeting MassHealth Standards
    5. Entity Identifier is not meeting MassHealth Standards

3. The Member File is ***not*** used as part of the claims validation process. Rejected records in the Member File do ***not*** result in rejecting records from Encounter Claims Data.

Member Enrollment File

1. All Member IDs submitted in the Member Enrollment File must exist in MMIS
2. All Member IDs submitted in the Member Enrollment File must exist in Member File

3. In the following scenarios, all records for that Member ID get rejected:
    - Member ID is missing
    - Member ID is invalid
    - Provider ID is missing
    - Provider ID is not found in MCE Provider Files
    - Provider ID Type is missing
    - Provider ID Type is not found in MCE Provider Files
    - Provider ID location is missingPractice ID Type is missing when Practice ID is not missing
    - Practice ID Type not found in MCE Provider Files when Practice
        - Practice ID location is missing ID is not missing
    - Provider Enroll Type is missing
    - Provider Enroll Type is not valid as per specification
    - Care Level is missing
    - Care Level is not valid as per specification
    - Begin Enrollment Date is missing or invalid
    - End Enrollment Date is missing or invalid
    - Org. Code is missing
    - The data in Member Enrollment File are not used as part of the claims validation process.
    - Rejected Member Enrollment File records do not result in rejecting records from Encounter Claims Data

***Care Management Provider File* – Not currently submitted**

1. All records in the Care Management Provider File will be rejected in the following scenarios:
    - **a.** Org. Code is missing
    - **b.** Org. Code is not meeting MassHealth Standards
    - **c.** CM Provider ID is missing

5. ***Member Error File:***

1. All records in the Member File, Member Enrollment File and Care Management Provider File not meeting validation rules described in Section 4 will be rejected.
2. An error file for the Member File will be posted on the FTP server and will be named "ERR_MCE_MEMBER_YYYYMMDD.txt". (e.g. ERR_BMC_MEMBER_20130930.txt)
3. An error file for the Member Enrollment File will be posted on the FTP server and will be named "ERR_MCE_MEMENROLL_YYYYMMDD.txt". (e.g. ERR_BMC_MEMENROLL_20130930.txt)
4. An error file for Care Management Provider File will be posted on the FTP server and will be named "ERR_MCE_CAREMGMT_YYYYMMDD.txt". (e.g. ERR_BMC_CAREMGMT_20130930.txt)
5. Records that get rejected must be corrected and sent back to MassHealth to get into the system.
6. Member and Member Enrollment correction files should follow the same format as the original files
7. Member and Member Enrollment correction files must be submitted with the Encounter correction/manual override file or must be corrected in the following month's member files submission.
8. Corrected records in Member File, Member Enrollment File or Care Management Provider File that still have errors will never go into MassHealth system and will not be overridden even when submitted along with the Manual Override Encounter file.

6. *File Layout:*

Member File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N	Required	
2	Member ID	The MassHealth ID for the **member**	12	C	Required	
3	Active Status Indicator	Y/N indicates whether the member has a current “Active” enrollment status with the MCE	1	C	Required	
4	Member Birth Date	Member Date of Birth	8	Date YYYYMMDD	Required	
5	Member Death Date	Member Date of Death	8	Date YYYYMMDD	Required	
6	Member First Name	Member first name	100	C	Required	
7	Member Last Name	Member last name	100	C	Required	
8	Member Middle Initial	Member Middle Initial	1	C	Required	

#	Field	Description	Length	Type	Required	Comments
9	Member Gender	The gender of the member: "Male" ; "Female", or “Other” These values should be spelled out and should not be abbreviated	8	C	Required	
10	Member Ethnicity	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
11	Member Race	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
12	Member Primary Language	The Primary Language of the Member	75	C	Provide if available	Values should have descriptions and not codes
13	Member Address 1	Member Street Address 1	100	C	Required	
14	Member Address 2	Member Street Address 2	100	C	Provider if applicable	
15	Member City	Member City	40	C	Required	
16	Member State	Member State	2	C	Required	
17	Member Zip Code	Member Zip Code	5	C	Required	
18	Homeless Indicator	Y/N. Indicates if the member is homeless	1	C	Provide if available	
19	Communication Access Needs Indicator	Y/N. Indicates if the member has special needs for communicator	1	C	Provide if available	
20	Disability Indicator	Y/N. Indicates if the member has a disability	1	C	Provide if available	
21	Disability Type	Identifies the disability type for a member. This is a place holder until the disability types are clearly defined. Values TBD	30	C	Provide if available	

Member Enrollment File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. **This code identifies your Organization :** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total	3	N	Required	
2	Member ID	The MassHealth ID for the **member**	12	C	Required	

#	Field	Description	Length	Type	Required	Comments
3	Provider Enroll Type	This field indicates the Type of Provider a member is enrolled with. It should reflect the information entered in the Provider ID and ID Type. For example, if Provider Enroll Type is entered as '02' then the Provider ID and ID Type should be for the "Geriatric Coordinator" the member is enrolled with. **The values are as follows:** **01 = PCP** **02 = Geriatric Coordinator** **03 = LTSS Coordinator** **04 = Care Coordinator** **05 = Care Coordination Program (if no assigned care coordinator but member is enrolled in a care coordination program)** **06 = Care Manager** **07 = Care Management Program (if no assigned care manager but member is enrolled in a care management program)**	2	C	Required	This is a key field and it indicates whether the provider fields are for a PCP or CM providers.
4	Provider Enroll Type Description	The Description of the Provider Enroll Type. The description should be consistent with the value selected in Provider Enroll Type. If the value entered in Provider Enroll Type is **"01"** the description should be "PCP" If the value entered in Provider Enroll Type is **"02"** the description should be " Geriatric Coordinator" and so on	40	C	Required	
5	Care Level	This field is required with all CM Providers to indicate whether the Provider ID submitted is at the MCE or Practice/Provider level. If the Provider is a PCP, value "NA" **must** be entered in this field. Values are: "MCE" "PRV" "NA" for "Not Applicable"	3	C	Required	
6	Begin Enrollment Date	This is the beginning enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	

#	Field	Description	Length	Type	Required	Comments
7	End Enrollment Date	This is the end enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	This value should be "99991231" for "active" enrollment which represents End of Time (EOT).
8	Provider ID	Provider ID.	15	C	Required	This ID should be consistent with the ID submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the “Provider Enroll Type” field above. For example, if the Provider Enroll Type was submitted on a record as “01” then the Provider ID for that record would be for a PCP. This applies to all other values in the Provider Enroll Type.

#	Field	Description	Length	Type	Required	Comments
9	Provider ID Type	Provider ID Type is required when the provider is part of prior and current provider files submitted in the encounter data. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Required	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type was submitted on a record as "01" then the Provider ID Type for that record would be the ID Type associated with a PCP. This applies to all other values in the Provider Enroll Type.
10	Practice ID	Practice ID	15	C	Highly important so please provide if available	This ID should be consistent with the ID submitted in the Encounter Provider File for a Practice
11	Practice ID Type	Practice ID Type. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Highly important so please provide if available	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a Practice
12	PCC Provider ID Address Location Code	Code to identify address location of Provider ID in Field #10.	5	C		

#	Field	Description	Length	Type	Required	Comments
13	PCC Practice ID Address Location Code	Code to identify address location of Practice ID in Field #10.	5	C		
14	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims Example: 999999999A	10	C	Required on all ACO claims	Should be consistent with ACO PIDSL submitted in the encounter provider file

***Care Management Provider File Layout* – Not currently submitted**

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	N	Required	
2	CM Provider ID	The MCE unique identifier for **CM Provider**	15	C	Required	
3	CM Provider Last Name	**CM Provider** last name	100	C	Required	
4	CM Provider First Name	**CM Provider** first name	100	C	Provide if Applicable	
5	CM Provider Gender	M' for Male ; 'F' for Female, and 'O' for "**Other"**	**1**	C	Optional	
6	CM Provider Address	**CM Provider** Street Address	120	C	Required	
7	CM Provider City	**CM Provider** City	40	C	Required	
8	CM Provider State	**CM Provider** State	2	C	Required	
9	CM Provider Zip Code	**CM Provider** Zip Code	9	C	Required	
10	CM Provider Phone	**CM Provider** Telephone number	13	C "9999999999"	Required	Do not include characters like dashes or brackets – e.g. 6178889900
11	CM Provider Effective Date	Begin effective date for the **CM Provider**	8	C – YYYYMMDD	Required	
12	CM Provider Term Date	End effective date for **CM Provider**	8	C – YYYYMMDD	Required	This value should be "99991231" for "active" CM Provider IDs which represents End of Time (EOT).
13	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims Example: 999999999A	10	C	Required	
14	CM Provider ID TYPE		1	N		
15	CM Provider ID Location code		5	C		

Appendix J: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
List of Suspended or Excluded MassHealth Providers	http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html	All providers which have been suspended or excluded by MassHealth	At enrollment & revalidation and as needed for all provider types
NPI – National Provider Identifier Verify provider's NPI	https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do	NPI Number, First Name, Last Name may be entered to verify that the provider is on the NPI database	At enrollment & revalidation and as needed for all provider types
OIG – CMS Office of Inspector General Verify exclusions	http://exclusions.oig.hhs.gov	Last name and first name are entered to see if there are any findings under the provider's name	At enrollment, revalidation & monthly for all provider types
BORIM – Mass. Medical Board Validate licenses, suspensions and actions	http://profiles.ehs.state.ma.us/Profiles/Pages/FindAPhysician.aspx	You may search by Name, Specialty, License Number or ZIP Code to validate the license and verify if findings that would prevent them from practicing in MassHealth	At enrollment, revalidation & weekly for all provider types
DEA Number Verify DEA number	https://www.deanumber.com	Last name, State if the provider is found, verify that the provider's DEA number is current and without issue	At enrollment & revalidation for all providers with a DEA
MedFile Verify exclusions	This file is downloaded from the Tibco server. MCOs should go to their SFTP site shared with CSC to download these files.	Last name, first name are searched from the drop down option to ensure the provider's name is not listed and that there are no current findings against them.	At enrollment, revalidation & monthly for all provider types
PEC States Verify other state's exclusions	This file is downloaded from the Tibco server. MCOs should go to their SFTP site shared with CSC to download these files.	View by last name, first name, and state to view termination data from CMS	At enrollment, revalidation & monthly for all provider types
DIA – Debarment List Verify debarments	http://www.mass.gov/lwd/workers-compensation/investigations/swos-issued.html	View debarment information by company name, address, city, and state to assure a provider is not listed	At enrollment & revalidation for all provider types
Licenses Verify exclusions	http://license.reg.state.ma.us/public/licque.asp?color=blue or https://checkalicense.hhs.state.ma.us/mylicenseverification/Search.aspx?facility=N	Verify individuals' licenses by number / business info / personal info to verify the license is current and there are no findings against the ID	At enrollment & revalidation for all provider types when there is a hit on Sam, LEIE, MedFile, OIG

Appendix J: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
SAM – System for Award Management	https://sam.gov/portal/SAM/#1	Enter the provider's last name then first name to verify that the provider is not on the SAM website	At enrollment, revalidation & monthly for all provider types
Death Master File Verify a provider is not listed as deceased	Download file with a subscription	Enter the provider's name and/or social security number to verify that any applicant or Reval provider is not on the death file	At enrollment & revalidation for all provider types
PECOS Verify provider's Medicare enrollment information You must have a user ID to access PECOS	https://ampedc3.cms.gov/amserver/cdcservlet?realm=legacyedc3&goto=https%3A%2F%2Fpecosai.cms.hhs.gov%3A443%2Fpecosai%2Flogin.action&RequestID=10148&MajorVersion=1&MinorVersion=0&ProviderID=https%3A%2F%2Fpecosai.cms.hhs.gov%3A443%2Famagent&IssueInstant=2015-04-14T09%3A51%3A42Z	Enter the provider's information (name and SS #) to verify that they have a Medicare number that is active.	At enrollment & revalidation for all provider types
CORI Submit verify any criminal record the within the state of Massachusetts You must have a user ID to access CORI	https://icori.chs.state.ma.us/icori/ext/login/login.action?_p=jrSw8VW0a8WNvtHhCjMVj3RacRdmZmDDlpMkSxSL5Iw	The CORI Request Form is to be completed by the provider types 07 or 61 submitted as part of their application to the CSC. All of the information on the form is entered. Access to CORI is limited and must be processed by those with access.	At enrollment & revalidation for applicable providers
JCAHO (Joint Commission) Verify provider's accreditation/certification status	http://www.qualitycheck.org/consumer/searchQCR.aspx#	You may search a provider based on name, zip code or state. JCAHO is checked for hospital that are applying or being revalidated as is required for complete credentialing.	At enrollment, revalidation and monthly for hospitals
NBCOT (Nat'l Board for Certification in Occupational Therapy Validate licenses and suspensions and actions	https://my.nbcot.org/OnlineCredentialVerification/	The certification page requests either the certification number or last name, first name. The results are reviewed for whether the provider is Active and if there are any actions against them currently or in the past	At enrollment, revalidation and monthly for therapists

Appendix J: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
ASHA (American Speech-Language-Hearing Assn.) Validate licenses and suspensions and actions	http://www.asha.org/eweb/ashadynamicpage.aspx?webcode=ccchome	The ASHA certification page requires either the 8-digit ASHA account number or the provider's first and last name as well as their state. The provider must be licensed by the Board of Speech and Language Pathology as well as be accredited by ASHA.	At enrollment, revalidation & monthly for hearing instrument specialists
CHAP (Community Health Accreditation Program) Validate licenses and suspensions and actions	http://www.chapapps.org/search/	The CHAP website is used to find an accredited Community Health Provider. The home page may be searched by either the Agency Name or by State. The results display the Organization, City and State, Accreditation Dates, and Services.	At enrollment, revalidation & monthly for CHCs
American Board of Opticianry Certification Validate licenses and suspensions and actions	http://www.abo-ncle.org/ABO/Certification/Search_Certification_Database/ABO/PublicQueries/Certification_Database.aspx	The ABO certification database is searched by last name, first name, city, state and zip. The results will display the Certificate holder, Company, Certification, City, State, ZIP, Status, and Expiration date.	At enrollment, revalidation & monthly for opticians
National Examining Board of Ocularists Validate licenses and suspensions and actions	http://www.neboboard.org/nebostaprov.htm	This website displays the National Registry of Board Certified Ocularists. There is no way to search by individual name.	At enrollment, revalidation & monthly for Ocularists
State of New Hampshire Board Actions Validate licenses and suspensions and actions	http://www.nh.gov/medicine/aboutus/actions/index.htm	The provider's name and /or license number is listed on the home page and then searched. Results will indicate the provider's license, start date, end date, expiration date, specialty, and schooling. It will also show "Remarks" indicating "status" such as inactive or dead.	At enrollment, revalidation & weekly verifications
State of Rhode Island Board Actions Validate licenses and suspensions and actions	http://www.health.ri.gov/lists/disciplinaryactions/	The disciplinary actions page has 3 options for search; License type, Find by Name, or Filter by Date. Results are reviewed for matches to any Massachusetts providers.	At enrollment, revalidation & weekly verifications
State of Connecticut Board Actions Validate licenses and suspensions and actions	http://www.ct.gov/dph/cwp/view.asp?a=4061&q=387280	The CT DPH displays a Regulatory Action Report that posts actions taken against providers by calendar year and quarter. There are 25 quarters posted which have to be searched individually.	At enrollment, revalidation & weekly verifications Usually updated quarterly

Appendix J: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
State of New York Board Actions Validate licenses and suspensions and actions	http://w3.health.state.ny.us/opmc/factions.nsf http://www.op.nysed.gov/opd/rasearch.htm	The NY BOH has a search page for Board Action regarding a particular Physician or Physician Assistant. The physician or PA may be entered with the last name; the license number may be searched; the license type may be searched; or the search may be done by entering the effective date of the disciplinary action.	At enrollment, revalidation & weekly verifications
State of Vermont Board Actions Validate licenses and suspensions and actions	http://healthvermont.gov/hc/med_board/actions.aspx	The Vermont DPH site has a page that is for Board Actions by Month. Yearly actions may be reviewed historically back to 2006 by month. There is no board action search by individual alone.	At enrollment, revalidation & weekly verifications
State of Maine Board Actions Validate licenses and suspensions and actions	http://www.maine.gov/md/discipline/adverse-licensing-actions.html	The State of Maine Board of Licensure in Medicine displays a page titled “Adverse Licensing Actions”. These actions are displayed by year with no search ability by individual alone.	Weekly verifications
MA Nursing Board Actions Validate licenses and suspensions and actions	https://checkalicense.hhs.state.ma.us/MyLicenseVerification/	The MA License Verification Site has search options for Profession, License Type, Name, License Number, and Status. For nursing searches the top three options for license status will be Suspension, Revocation and Probation.	Monthly verifications

APPENDIX K

MATERIAL SUBCONTRACTOR CHECKLIST

Below is a list of questions related to [***insert name of MCE***] preparedness for entering into a contract with a Material Subcontractor [***Insert name and type of subcontractor***]. **The Contractor shall provide a written response to these questions no later than 60 days prior to contract execution.**

Name of MCE:_____ Date of Submission:_____

Date of Resubmissions (if applicable): _____

SECTION 1

Please answer all questions completely. If a question is not applicable, insert N/A throughout.

GENERAL INFORMATION

1. What is the name of the Material Subcontractor?
2. What is the type and scope of service to be provided by the Subcontractor (e.g. PBM, Behavioral Health, claims processing, care management, mail order pharmacy)?
3. What is the expected effective date of the Subcontract?
4. What is the expected date on which the Subcontractor will begin to deliver services, if different from the expected effective date of the Subcontract (due to ramp up time or other implementation factors)?
5. What are the key reasons for choosing to contract with Subcontractor to perform these activities?
6. What are the key reasons for selection of this Subcontractor?
7. What are the primary services that this Subcontractor will perform, including the business functions, and/or the range of health conditions on which this Subcontractor will focus?
8. What specific services will the Subcontractor provide? If comparable services are to be provided by the MCE, how will the services provided by this Subcontractor differ from those provided by MCE and why are such redundancies necessary?
9. Confirm that the MCE has ensured and explain how the MCE has ensured that the Subcontractor is financially sound.

SUBCONTRACTOR REIMBURSEMENT

10. How will the Subcontractor be reimbursed? If reimbursement is on a PMPM, will the reimbursement be based on enrollees referred or enrollees served? If based on enrollees served, please provide a definition of "served" in this respect.

11. Provide a summary of the ROI review conducted to justify the anticipated gains and potential cost savings as an offset to the increased administrative expenditure.

MCE STAFF TRAINING AND COORDINATION

12. How and when will MCE Enrollee Services and all other MCE business units' staff be trained about the Subcontractor?

13. Submit copies of the relevant training materials.

14. Will the MCE designate staff to interact with the Subcontractor? If so, which staff and how many will be designated? Will interactions between staff and the Subcontractor take place in-person or remotely or both?

15. Specify the nature of coordination and communication that will occur between the Subcontractor and MCE staff.

16. Describe the nature of communication and coordination, and transfer of information, between this Subcontractor and other Subcontractors, as applicable, for each of the above listed interactions. Include the role of the MCE for each.

NOTIFICATION OF AND EFFECTS ON ENROLLEES (IF APPLICABLE)

17. How many Enrollees in total will the Subcontractor serve? How will Enrollees be identified for this service?

18. Will the Subcontractor operations be visible or transparent to Enrollees?

19. How and when will existing Enrollees be notified of the role and availability of the Subcontractor? **Submit draft copies of the relevant notification letters/materials.**

20. Will new Enrollee identification cards be sent? If so, how and when?

21. Identify any differences in access to Enrollee services that may result from having this Subcontractor and, if access is more limited, the nature and timing of outreach to Enrollees.

22. Describe any other anticipated effects of the Subcontractor's on Enrollees' engagement with the MCE.

NOTIFICATION OF AND EFFECTS ON PROVIDERS (IF APPLICABLE)

23. Will the Subcontractor operations be visible or transparent to Providers?

24. How and when will the MCE provider network be informed about the Subcontractor? **Please submit draft copies of the relevant notification and training materials.**

25. How will the MCE ensure that PCPs are aware and approving of any information that the Subcontractor presents to Enrollees?

26. Identify any differences in access to Provider services that may result from having this Subcontractor and, if access is more limited, the nature and timing of outreach to Providers.

27. Describe any other anticipated effects of the Subcontractor on Providers.

SYSTEMS/ DATA

28. Will the Subcontractor have retrospective or live access to any MCE systems? If so, which system(s)?

29. Describe data elements to be shared between the Subcontractor and the MCE.

30. Describe the process for data sharing between the Subcontractor and the MCE.

31. How will data generated by the Subcontractor be integrated into MCE system(s), if applicable? How will data in the MCE system be transferred to the Subcontractor, if applicable? What will be the frequency of such integration? How will data integrity be ensured? Explain the arrangement that will ensure the Enrollee has the full range of recourse via the grievance and appeal system, including timely notifications and resolutions of processes.

32. Describe any expected loss of data history due to implementation of the Subcontract, if any.

33. Describe how the MCE will manage any unanticipated loss of data/information due to implementation of the Subcontract.

34. Does the MCE intend to operate redundant IT systems before a new system is relied upon solely? If so, for how long and how will the MCE manage such redundancy of systems?

35. Describe the process that will be used to ensure that the IT system will have capacity to interface with New MMIS effectively, as applicable.

READINESS REVIEW

36. Describe the readiness review that the MCE will conduct of the Subcontractor, including timeframes.

37. Provide the MCE's contingency plan should the Subcontractor not be ready to operate by the expected implementation date. At what point will this contingency plan be implemented?

38. Has the Subcontractor worked with MassHealth or other Medicaid populations and/or within the MA market? If so, address prior experiences and measures of performance, including results of services implemented, if known.

39. Describe the training and education that the MCE will provide to the Subcontractor regarding the MCE and the MassHealth population.

EVALUATION

40. Describe how the Subcontractor's performance will be evaluated. Does the MCE plan to evaluate the Subcontractor, or will the Subcontractor conduct the evaluation independently? If the Subcontractor will self-evaluate, what role, if any, will the MCE play in the evaluation?

41. How will the MCE ensure effective Subcontractor participation in all EQRO related activities?

42. How will the MCE ensure the Subcontractor's compliance with all MassHealth MCE Program contractual provisions, including those relating to confidentiality of information and Marketing?

43. Reference any national, state, and/or local standards to which the Subcontractor will adhere.

SECTION 2

Please answer all questions completely within the area below that are applicable to the new Subcontractor type.

Behavioral Health Subcontractor:

1. What are the MCE's reasons for deciding to subcontract for some or all of its behavioral health operations?

2. Describe the MCE's planned management structure of the behavioral health carve-out vendor.

3. How will the behavioral health material subcontract support the integration of physical and behavioral medical care management? How will care management be structured for enrollees with both medical and behavioral health issues that require care management?

PBM:

What are the MCE's key reasons for selecting this PBM, or switching from the current PBM?

Mail Order Pharmacy:

1. What are the key reasons for proposing a Mail Order Pharmacy (MOP) program?

2. Provide an overview and description of the proposed MOP program.

3. Provide a list of the therapeutic drug categories and covered drugs that will be included and excluded in the MOP program, along with a description of the inclusion/exclusion criteria. Describe the process that will be used to monitor and mitigate inappropriate early refills. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

4. Describe the process that will be used to minimize the risk of drug diversion. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

5. Describe the process that will be used to provide emergency access (i.e. weekends, after hours, vacation, etc.) if a enrollee does not receive the prescription drug in a timely manner. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

6. Describe the process that will be used to ensure that enrollees are fully informed and provided an opportunity to raise questions and concerns regarding the risks and side effects of the drugs received through the MOP Program. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

7. Describe the process that will be used to ensure that a enrollee will not be denied medications as a result of not paying a copayment. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

Care Management:

1. Describe the process that will be used to transfer the active caseloads of enrollees currently receiving Care Management from the MCE and/or other Subcontractor to the new Subcontractor.

2. Describe the process that will be used to ensure minimal disruption to enrollees and/or care management systems. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

3. Describe the process that will be used to ensure effective communication and coordination between the Subcontractor, PCPs of enrollees in care management, and the MCE. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

Utilization Management

Describe the mechanisms it will use to ensure that subcontractor managed levels of service utilization are appropriate and simultaneously ensure high quality care in a manner that would not impede access to medically necessary care.

Claims:

1. Describe the process that will be used to transfer the current claims processing system to the new claims processing system.
2. Describe the process that will be used to ensure minimal disruption to claims processing and other IT functions, including timely and appropriate payment of claims. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?
3. Describe the process that will be used to ensure that any prior approvals granted under the current system will be honored under the Subcontractor.
4. Describe the process that will be used to ensure that claims will not be double-paid by the current and the new Subcontractor during transition. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?
5. Explain what steps will be taken to be sure the new claims system can properly perform all the interfaces with MMIS that are required.
6. Describe steps to ensure MassHealth reporting will not be negatively impacted

Call Center

1. Describe the process for handling various types of calls from MassHealth enrollees.
2. Is a separate entity responsible for handing calls for MassHealth Enrollees, prospective enrollees, and/or enrollees in other product lines? If so, what is the nature of referral and coordination between the Subcontractor(s) and MCE?
3. Please describe how the process for handling various types of calls differs for MassHealth enrollees, prospective enrollees, and/or enrollees in other product lines, if applicable
4. How will the MCE ensure that all required enrollee notifications occur in a timely and effective manner?

Other Comments:

Appendix L
Quality Improvement Program Initiatives

1. INTRODUCTION

This appendix describes the requirements for performance improvement projects described as part of the quality management requirements in section 2.9 of the Contract.

SCOs must develop at least two distinct Performance Improvement Projects annually. SCOs are expected to collect and report on all measures and interventions in each QI domain as specified or approved by EOHHS. EOHHS will provide standardized forms for all required reporting activities, including Quality Improvement Plans, Progress Reports, and Annual Reports.

Reporting for Performance Improvement Projects spans a 3-year period which includes planning/baseline, mid-cycle, and final evaluations to allow for tracking of improvement gains. For each QI cycle (3-year period), EOHHS will establish a series of QI Program Initiatives as well as approve and/or designate measurement and quality improvement activities.

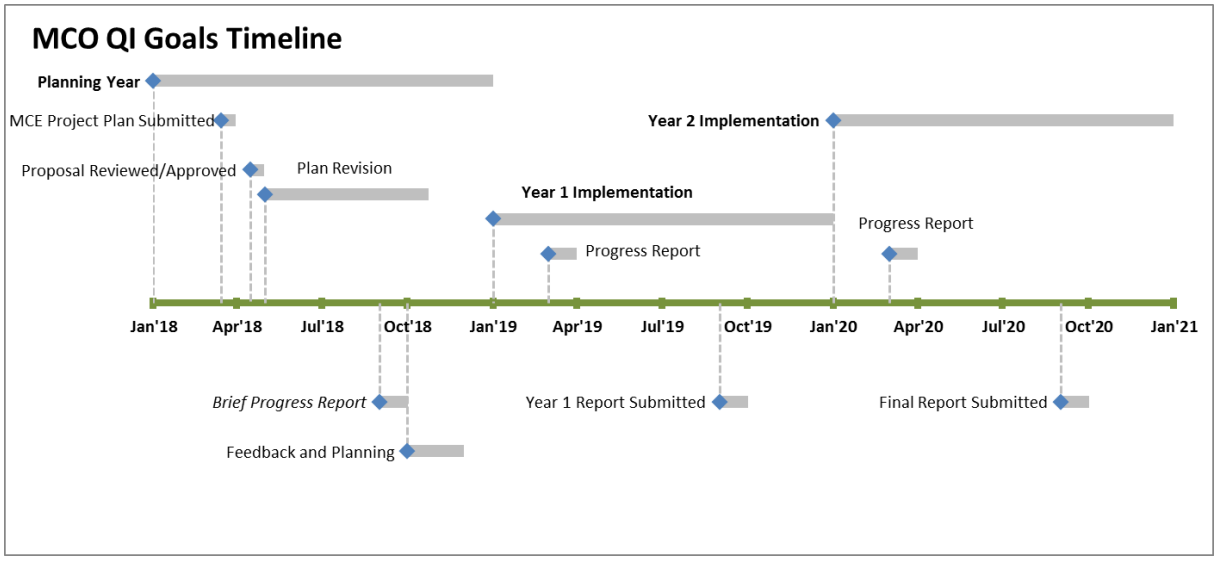
2. QI IMPLEMENATION DETALS

The following section provides detailed information about the QI Management Program implementation periods, their associated activities and timelines.

TABLE 1: PIP IMPLEMENTATION PERIODS AND ASSOCIATED ACTIVITIES	
Cycle 1: January 1, 2018 – December 31, 2020	
Baseline/Initial Implementation Period: January 1, 2018 – December 31, 2018	• *Planning Phase*: *January- March 2018* SCOs engage in detailed project planning in an effort to develop a data-driven, evidence-based plan for interventions using quality improvement principles. Tasks include but are not limited to the development of a problem statement, a review of evidence-based literature, and interventions to address the problem, and completion of quality improvement tools and activities that support project planning including root causes analyses, barrier analyses, development of driver diagrams, population analyses. • *Quality Improvement Plan Submission: March 2018* SCOs submit QI proposals to the MassHealth or its designee for review and approval. Proposals will describe planned activities and data collection plans for initial implementation. • *Initial Implementation: May 2018-December 2018* SCOs modify QI plans for year 1 based on feedback

	received from EOHHS. SCOs may focus on developing stakeholder engagement, process mapping and implementation of small test of change to inform initial Implementation. **In September 2018,** SCOs submit brief progress report detailing **baseline year data (CY 2017)**, description of activities currently underway, and plans for Mid-cycle Implementation.
Mid-cycle Implementation Period: Calendar Year 18 (January 1, 2019 – December 31, 2019)	• *Mid-Cycle Launch: January 2019* SCOs implement Mid-cycle interventions and collect data on short-term indicators. • *Mid-Cycle Progress Reports*: *March 2019* SCOs submit Progress reports detailing changes made as a result of feedback or lessons learned in the previous cycle. Plans will provide updates on the current year's interventions and identify challenges for discussion and problem-solving with EOHHS or its designee. • *Mid-Cycle Annual Report: September 2019* SCOs submit annual reports describing current interventions, report on short-term indicators, HEDIS data as applicable, and assess results including success and challenges. Reports will also include plans for final implementation period modifications.
Final Implementation Period: Calendar Year 19 (January 1, 2020 – December 31, 2020)	• *Final Implementation Launch: January 2020* SCOs implement Mid-cycle interventions and collect data on short-term indicators. • *Final Implementation Progress Reports*: *March 2020* SCOs submit Progress reports detailing changes made as a result of feedback or lessons learned in the previous cycle. Plans will provide updates on the current year's interventions and identify challenges for discussion and problem-solving with EOHHS or their designee. • *Final Implementation Annual Report: September 2020* SCOs submit annual reports describing current interventions, report on short-term indicators, HEDIS data as applicable, and assess results including success and challenges. Reports will also include plans for the final quarter of QI activities.

Figure 1: QI Goals Timeline



QI goal cycle 2 will begin January 1, 2021 and conclude December 31, 2023. The activities associated with Cycle 2 will mirror those outlined for Cycle 1. However, QI Goal activities, requirements, and domains are subject to changed given EOHHS needs and priorities.

3. SCO PIP Topics: CYCLE 1, January 1, 2018 – December 31, 2020

Topic descriptions and goals are outlined in Table 1: Domain Areas and Goals.

Table 1: Domain Areas and Goals	
Domain 1: Behavioral Health - Promoting well-being through prevention and treatment of mental illness including substance use and other dependencies.	
Goals:	• To increase the delivery of behavioral health services. • Achieve better behavioral health outcomes. • Improve the overall behavioral health of the plan's population, especially those with mental illness and substance abuse.
Domain 2: Chronic Disease Management: - Providing services and assistance to Enrollees with or at risk for specific diseases and/or conditions.	
Goals:	• To identify members at risk for one or more chronic conditions and address risk factors that contribute to disease. • To improve the quality of life for members with one or more chronic conditions through self-management and adherence to treatment.

4. Measures and Interventions:

Specific measures and interventions will be determined during the submission and review of the SCO's Quality Improvement Plan.

5. SCO Reports, Submissions, and Templates:

Participating SCOs will submit to MassHealth or its designee:

- One Quality Improvement Plan and one Annual Report during the Planning/Baseline Implementation period;
- One Progress Report and one Annual Report during each re-measurement period.

SCOs should refer to Table 1 (QI Goal Implementation Period and Associated Activities) for reporting timeframes.

SCOs will submit Quality Improvement Plans and Reports using the submission templates to be developed and distributed by EOHHS on or before January 30, 2018. Additionally, SCOs will submit data on all quality metrics included in Exhibit 1 of this document. SCOs are required to submit their IDSS table for all HEDIS quality metrics.

QI Reporting submissions shall include quantitative and qualitative data as well as specific progress made to each measure, barriers encountered, lessons learned, and planned next steps. For specific instructions on the submission process and detail on the submission templates, SCOs shall refer to the Submission Guide to be on distributed on or before January 30, 2018.

Reporting on the interventions should at minimum include the following items (to be described with greater specificity in the forthcoming Submission Guide Document):

- Rationale for selecting proposed/implemented interventions
- Description of current interventions
- Analysis of short-term indicators, HEDIS rates as applicable, data collection procedures and methodology, and interpretation of results
- Assessment of intervention successes and challenges, and potential intervention modifications for future implementation periods.

Evaluation of QI Reports: EOHHS or its designee will review annual reports using a standardized Evaluation Template. The scoring elements in the Evaluation Template will correspond directly with the elements documented on the reporting templates. Feedback will be provided to the SCOs for each implementation period.

Cultural Competency

Participating SCOs shall design and implement all QI activities and interventions in a culturally competent manner.

Exhibit 1: Quality Measures

EOHHS has defined the following quality measures pursuant to Section 2.14 of the Contract. For measures that are not HEDIS, EOHHS will further define measure specifications, including due dates, sample size, and submission requirements. These measures are to be submitted annually to EOHHS. The Contractor should report measures separately for Dual Eligible and Medicaid only eligible Enrollees. This list is subject to modifications.

	Measure Name	NQF_ ID	Set	Domain
1	**Annual monitoring for patients on persistent medications (MPM)**	2371	HEDIS	Patient Safety
2	**Antidepressant Medication Management (AMM)**	0105	HEDIS	Behavioral Health and Substance Abuse
3	**Board Certification**	NA	HEDIS	
4	**Care for Older Adult (COA) - Advanced care planning**	0326	HEDIS	Care Coordination & Transitions
5	**Colorectal Cancer Screening (COL)**	0034	HEDIS	Screening and Prevention
6	**Controlling high blood pressure (CBP)**	0018	HEDIS	At Risk Populations
7	**Eye examination every two years: percentage of Enrollees who received vision screening in the past two years**	N/A	CMS/EHS requirement	
8	**Follow-Up After Hospitalization for Mental Illness (FUH)**	0576	HEDIS	Behavioral Health and Substance Abuse
9	**Hearing examination every two years: percentage of Enrollees who received a hearing screening in the past two years.**	N/A	CMS/EHS requirement	
10	**Influenza immunization**	0041		Screening and Prevention
11	**Medication Reconciliation Post-Discharge (MRP)**	0097	HEDIS	Care Coordination & Transitions
12	**Consumer Assessment of Healthcare Providers and Services (CAHPS)**	N/A		
13	**Osteoporosis Management in Women Who Had a Fracture (OMW)**	0053	HEDIS	Screening and Prevention
14	**Persistence of Beta-Blocker Treatment after Heart Attack (PBH)**	0071	HEDIS	At Risk Populations
15	**Pharmacotherapy Management of COPD Exacerbation (PCE)**	0549	HEDIS	At Risk Populations

	Measure Name	NQF_ ID	Set	Domain
16	**Plan All-Cause Readmissions (PCR)**	1768	HEDIS	Outcomes
17	**Pneumococcal Immunization (PPV 23) (IMM-1a)**	1653	Hospital Inpatient Quality Reporting (HIQR)	Screening and Prevention
18	**Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)**	NA	HEDIS	At Risk Populations
19	**Screening for alcohol abuse: percentage of Enrollees reporting alcohol utilization in the CAGE risk areas, and percentage of those referred for counseling.**	N/A	CMS/EHS requirement	
20	**Use of high risk medications in the elderly (DAE)**	0022	HEDIS	At Risk Populations
21	**Use of spirometry testing in the assessment and diagnosis of COPD (SPR)**	0577	HEDIS	At Risk Populations

Appendix M: Comprehensive Assessment

The EOHHS-designated Comprehensive Assessment is the Minimum Data Set – Home Care (MDS-HC) 2.0.

Appendix N: MassHealth Rate Cells and Transitions Between Rate Cells

I. MassHealth Rate Cells (RCs)

MassHealth will pay the Contractor monthly capitation amounts for Enrollees according to the RCs in **Appendix _E_**MassHealth Capitation Rates for community-based Enrollees will vary according to three regions: Eastern, Western, and the Cape. These regions are defined by the county of the Enrollee's residence. A table of counties for each region is attached as **Appendix F**.

	Community Settings of Care			**Institutional Settings of Care**		
	Other	**BH***	**NHC***	**Tier 1***	**Tier 2***	**Tier 3***
Dual Eligible, Eastern	RC 20	RC 23	RC 26	RC 29	RC 30	RC 31
Dual Eligible, Western	RC 21	RC 24	RC 27	RC 29	RC 30	RC 31
Dual Eligible, The Cape	RC 22	RC 25	RC 28	RC 29	RC 30	RC 31
MassHealth Only, Eastern	RC 32	RC 35	RC 38	RC 41	RC 42	RC 43
MassHealth Only, Western	RC 33	RC 36	RC 39	RC 41	RC 42	RC 43
MassHealth Only, The Cape	RC 34	RC 37	RC 40	RC 41	RC 42	RC 43

*BH is Behavioral Health. NHC is Nursing Home Certifiable.

See **Subsections 4.2(D), (E) and (F)** below for a description of tier levels.

Community Other

If an Enrollee is a community resident, does not meet NHC criteria, and does not have a diagnosis of Behavioral Health / Substance Use Disorder, the Enrollee will be classified as Community Other.

RC 20: Community Other, Dual Eligible, Eastern

If the Community Other Enrollee is Dual Eligible and resides in the Eastern region, the Contractor will be paid a monthly RC 20 rate for every month in which the Enrollee remains in this RC.

RC 21: Community Other, Dual Eligible, Western

If the Community Other Enrollee is Dual Eligible and resides in the Western region, the Contractor will be paid a monthly RC 21 rate for every month in which the Enrollee remains in this RC.

RC 22: Community Other, Medicaid Only, the Cape

If the Community Other Enrollee is Dual Eligible and resides on the Cape, the Contractor will be paid a monthly RC 22 rate for every month in which the Enrollee remains in this RC.

RC 32: Community Other, Medicaid Only, Eastern

If the Community Other Enrollee is Medicaid Only and resides in the Eastern region, the Contractor will be paid a monthly RC 32 rate for every month in which the Enrollee remains in this RC.

RC 33: Community Other, Medicaid Only, Western

If the Community Other Enrollee is Dual Eligible and resides in the Western region, the Contractor will be paid a monthly RC 33 rate for every month in which the Enrollee remains in this RC.

RC 34: Community Other, Medicaid Only, The Cape

If the Community Other Enrollee is Medicaid Only and resides in the Western region, the Contractor will be paid a monthly RC 33 rate for every month in which the Enrollee remains in this RC.

Community Behavioral Health (BH)

If an Enrollee is a community resident, does not meet NHC criteria, and has a diagnosis of BH/SUD, the Enrollee will be classified as Community BH.

RC 23: Community BH, Dual Eligible, Eastern

If the Community BH Enrollee is Dual Eligible and resides in the Eastern region, the Contractor will be paid a monthly RC 23 rate for every month in which the Enrollee remains in this RC.

RC 24: Community BH, Dual Eligible, Western

If the Community BH Enrollee is Dual Eligible and resides in the Western region, the Contractor will be paid a monthly RC 24 rate for every month in which the Enrollee remains in this RC.

RC 25: Community BH, Dual Eligible, the Cape

If the Community BH Enrollee is Dual Eligible and resides on the Cape, the Contractor will be paid a monthly RC 25 rate for every month in which the Enrollee remains in this RC.

RC 35: Community BH, MassHealth Only, Eastern

If the Community BH Enrollee is MassHealth only and resides in the Eastern region, the Contractor will be paid a monthly RC 35 rate for every month in which the Enrollee remains in this RC.

RC 36: Community BH, MassHealth Only, Western

If the Community BH Enrollee is MassHealth only and resides in the Western region, the Contractor will be paid a monthly RC 36 rate for every month in which the Enrollee remains in this RC.

RC 37: Community BH, MassHealth Only, the Cape

If the Community BH Enrollee is MassHealth only and resides in on the Cape, the Contractor will be paid a monthly RC 37 rate for every month in which the Enrollee remains in this RC.

Nursing Home Certifiable (NHC)

If an Enrollee is a community resident, is limited in two or more activities of daily living (ADLs), and has a skilled nursing need three or more times per week, as recorded through the Minimum Data Set-Home

Care (MDS-HC) form and approved by EOHHS, or if an Enrollee is in the first three months of a nursing facility stay, the Enrollee will be classified NHC.

RC 26: NHC, Dual Eligible, Eastern

If the Enrollee is Dual Eligible and resides in the Eastern region, the Contractor will be paid a monthly RC 26 rate for every month in which the Enrollee remains in this RC.

RC 27: NHC, Dual Eligible, Western

If the Enrollee is Dual Eligible and resides in the Western region, the Contractor will be paid a monthly RC 27 rate for every month in which the Enrollee remains in this RC.

RC 28: NHC, Dual Eligible, the Cape

If the Enrollee is Dual Eligible and resides on the Cape, the Contractor will be paid a monthly RC 28 rate for every month in which the Enrollee remains in this RC.

RC 38: NHC, MassHealth Only, Eastern

If the Enrollee is MassHealth only and resides in the Eastern region, the Contractor will be paid a monthly RC 38 rate for every month in which the Enrollee remains in this RC.

RC 39: NHC, MassHealth Only, Western

If the Enrollee is MassHealth only and resides in the Western region, the Contractor will be paid a monthly RC 39 rate for every month in which the Enrollee remains in this RC.

RC 40: NHC, MassHealth Only, the Cape

If the Enrollee is MassHealth only and resides on the Cape, the Contractor will be paid a monthly RC 40 rate for every month in which the Enrollee remains in this RC.

Institutional Tier 1

If an Enrollee has more than a three-month consecutive stay in an institutional long term care setting, continues to reside in a nursing facility, and is classified into Management Minute Categories (MMC)

level H, J, or K, the Enrollee will be classified as Institutional Tier 1. The Contractor will be paid a monthly RC 29 rate for Dual Eligible Enrollees or a monthly RC 41 rate for MassHealth-only Enrollees for every month in which the Enrollee remains in this RC.

The Contractor will also be paid at the Institutional Tier 1 rate (RC 29 or RC 41) for those months which fall in the first three months after an Enrollee's discharge from a nursing facility to a community setting.

Institutional Tier 2

If an Enrollee has more than a three-month consecutive stay in an institutional long term care setting, continues to reside in a nursing facility, and is classified into Management Minute Categories (MMC) level L, M, N, P, R, or S, the Enrollee will be classified as Institutional Tier 2. The Contractor will be paid a monthly RC 30 rate for Dual Eligible Enrollees or a monthly RC 42 rate for MassHealth-only Enrollees for every month in which the Enrollee remains in this RC.

The Contractor will also be reimbursed at the Institutional Tier 2 rate (RC 30 or RC 42) for nursing facility residents who have elected hospice and who have resided in a nursing facility for more than three months.

Institutional Tier 3

If an Enrollee has more than a three-month consecutive stay in an institutional long term care setting, continues to reside in a nursing facility, and is classified into Management Minute Category (MMC) level T, the Enrollee will be classified as Institutional Tier 3. The Contractor will be paid a monthly RC 31 rate for Dual Eligible Enrollees or a monthly RC 43 rate for MassHealth-only Enrollees for every month in which the Enrollee remains in this RC.

II. Transitions between Rate Cells

MassHealth Capitation Rates will be updated following a change in an Enrollee's status, based on the Comprehensive Assessment tool proscribed by EOHHS and the Status Change Form (SC-1) for Nursing Facility Residents, or any subsequent forms required by EOHHS. The MassHealth transition rules are as follows:

A. Institutional to Community RC

For a transition from an institutional RC (Tier 1, 2, or 3) into a community RC, the rate change will become effective on the first calendar day of the month following 90 calendar days after discharge.

Between Community RCs

For a transition between community RCs, if the MDS-HC form is received and approved on or before the last day of the month, the rate change will become effective on the first calendar day of the following month.

Between Institutional RCs

For a transition between institutional RCs, the rate change will become effective on the first calendar day of the month after the MDS 3.0 is received and approved by EOHHS.

Community to Institutional RC

For a transition from one of the community RCs into an institutional RC (Tier 1, 2, or 3), the rate will first change to NHC, if the Enrollee is not already assigned to that RC, on the first day of the month after the Enrollee becomes institutionalized. If the Enrollee has not been discharged after 90 calendar days, the rate will change to the appropriate institutional RC (Tier 1, 2, or 3) on the first day of the month following 90 calendar days at the NHC rate.

SCO Model Contract Appendix O, effective January 1, 2018

SCO Encounters Quarterly Performance Report Template			
Field #	Field Name	Completion %	
		Actual	Benchmark
2	Claim category	X%	100%
4	Record indicator	X%	100%
11	Medicare Code	X%	100%
15	Admission Date	X%	100%
16	Discharge Date	X%	100%
17	From Service Date	X%	100%
18	To Service Date	X%	100%
19	Primary Diagnosis	X%	100%
24	Type of Admission	X%	100%
25	Source of Admission	X%	100%
26	Procedure Code	X%	100%
27	Procedure Modifier 1	X%	100%
31	Revenue Code	X%	100%
32	Place of Service	X%	100%
33	Place of Service Type	X%	100%
34	Patient Discharge Status	X%	100%
36	Quantity	X%	100%
37	NDC number*	X%	100%
40	Refill Indicator*	X%	100%
41	Dispense as Written Indicator*	X%	100%
50	Servicing Provider ID	X%	100%
51	Servicing Provider ID Type	X%	100%
55	Servicing Provider Type	X%	100%
56	Servicing Provider Specialty	X%	100%
58	Billing Provider ID	X%	100%
60	Billed Charge	X%	100%
61	Gross Payment Amount	X%	100%
63	Medicare Amount	X%	100%
67	Dispensing fee*	X%	100%
68	Net Payment	X%	100%
76	New Member ID	X%	100%
80	Service Category	X%	100%
81	Prescribing Prov. ID*	X%	100%
82	Date Script Written*	X%	100%
85	Admitting Diagnosis	X%	100%
86	Allowable amount	X%	100%
93	Billing Provider ID Type	X%	100%
94	Prescribing Prov. ID Type*	X%	100%
124	Patient Pay Amount	X%	100%
193	ICD Version Qualifier	X%	100%
198	Prescription Number*	X%	100%

*Completion % benchmark applied to pharmacy claims only

Note: For detailed explanation of fields, please reference Appendix I, "EOHHS Encounter Data Specifications."

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Significant changes to the approved waiver that are being made in this renewal application are limited to the following:
1. Added the following new services to support greater self-sufficiency for participants: Cellular PERS, Goal Engagement Program, Evidence Based Education Program, Orientation and Mobility Services and Peer Support.
2. Updated the service descriptions and re-named the following services: Home Safety/Independence Evaluations (formerly Occupational Therapy) and Complex Care Training and Oversight (formerly Skilled Nursing).

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Massachusetts** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Frail Elder Waiver

C. **Type of Request: renewal**

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MA.0059
Waiver Number:MA.0059.R07.00
Draft ID: MA.022.07.00

D. **Type of Waiver** *(select only one):*

Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*

01/01/19

Approved Effective Date: 01/01/19

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☑ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

PURPOSE:

Many elders who are nursing facility eligible prefer to remain in their homes in the community when sufficient supports can be put into place to maintain them safely in this setting. The purpose of the Frail Elder Waiver is to make such supports available to frail elders, aged 60 and older who have been determined through an assessment process to meet a nursing facility level of care and require supports to reside successfully in the community. Included in this waiver are individuals with a variety of needs that can be met through supports that range from basic to intensive levels.

GOAL:

The goals of the Frail Elder Waiver include: maintaining eligible elders in a home setting, avoiding, delaying or shortening nursing facility stays, meeting the wishes of elders who prefer to stay in their homes, and providing cost effective, high quality alternatives to support elders' home and community based service needs.

ORGANIZATIONAL STRUCTURE:

The Executive Office of Elder Affairs (EOEA or Elder Affairs) is an agency under the umbrella of the Executive Office of Health and Human Services (EOHHS), the single state agency. As such EOEA is under the administrative authority of EOHHS. EOEA is responsible for providing supports to elders, and is directly responsible for the oversight of the day-to-day operation of the Frail Elder Waiver on behalf of EOHHS. The EOHHS MassHealth Office of Long Term Services and Supports (LTSS) oversees the provision to eligible members of long term services and supports including through the Senior Care Options program, a Massachusetts integrated managed care program for eligible elders. EOEA and MassHealth meet regularly and collaborate on organizational matters, waiver management, qualify reporting and other aspects of waiver administration.

Elder Affairs contracts with and oversees the on-going responsibilities of 26 non-profit agencies called Aging Services Access Points (ASAPs), most of which are also Area Agencies on Aging. Waiver participants age 65 and older may choose to voluntarily enroll in a Senior Care Organization (SCO) which is a Medicaid managed care plan that manages all covered State Plan and Frail Elder Waiver services for enrolled members who are waiver participants. ASAPs and SCOs are responsible for assessing clinical level of care (LOC) for FEW participants (initial LOC for all waiver participants is done through an ASAP), conducting needs assessments, developing and monitoring services plans, conducting administrative case management functions and reporting client and quality-related data to Elder Affairs. Case management is provided to waiver participants as an administrative activity. Elder Affairs conducts oversight of all ASAP activities and the MassHealth Office of Long Term Services and Supports (LTSS) conducts oversight of all SCOs. Elder Affairs leads efforts and reviews quality jointly with LTSS.

SERVICE DELIVERY:

Through development of a person-centered service plan, waiver services are planned, authorized, arranged for and monitored by the case manager. Waiver participants who choose to enroll in a SCO will receive all waiver services through the SCO as well as work with an ASAP-employed Case Manager (the Geriatric Services Supports Coordinator, GSSC) under a contract between an ASAP and the SCO. Waiver services delivered through traditional service ASAP service delivery model use a network of contracted direct care providers. As noted, waiver services are coordinated and authorized through, and service

delivery is arranged and monitored by, the Case Manager.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**

○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies

the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
The Massachusetts Executive Office of Health and Human Services (EOHHS) held the 30-day public comment period from June 21 - July 23, 2018. EOHHS outreached broadly to the public and to interested stakeholders to solicit input on the renewal application for this waiver. The waiver renewal application was posted to MassHealth's website, and public notices were issued in multiple newspapers, including: The Boston Globe, The Worcester Telegram and Gazette, and The Springfield Republican. In addition, emails were sent to several hundred recipients including key advocacy organizations and the Native American tribal contacts. The newspaper notices and email provided the link to the MassHealth webpage on which the draft renewal application, dates for the public comment period, and, for anyone wishing to send comments, both email and mailing addresses were posted. The state received oral comments at a public listening session as well as written comments through email from 14 individuals and organizations on the proposed renewal application. Commenters included advocacy organizations, industry associations, Senior Care Options (SCO) plans, state agencies, and other stakeholders.

The comments received addressed several aspects of the renewal application, including: waiver services and providers; participant direction; slot capacity and growth in the waiver; clinical and financial eligibility requirements; the waiver application process; quality assurance measures and processes; settings in which waiver services can be delivered; support for caregivers of waiver participants; and SCO-related questions. EOHHS reviewed all comments and, in response to comments, made the following changes to Appendix C-1/C-3 of the waiver renewal application:

- In the service definition for Senior Care Options, EOHHS added clarification that enrollment in SCO does not substitute for the requirement that participants receive at least one waiver service per month as a condition of continued waiver eligibility.
- In the service definition for Enhanced Technology/Cellular PERS, EOHHS also updated the language to explicitly include fall detection technology and to clarify that waiver participants may not receive waiver Cellular PERS and conventional PERS covered under the State Plan at the same time.
- In the service definition for Supportive Home Care Aide, EOHHS added clarification that the Home Care Aide Council Mental Health Supportive Home Care Aide training curriculum or equivalent is required for Mental Health Supportive Home Care Aides.

EOHHS will continue to offer clarification about access to both waiver and non-waiver (i.e., State Plan) services for waiver participants through the person-centered planning process. EOHHS engaged with ASAPs and SCOs to answer

questions and to provide clarification on updates to the waiver, and will continue to engage with ASAPs and SCOs to support them in serving waiver participants. EOHHS continues to monitor at the participant, provider, and systems levels to ensure participants have access to needed services.

EOHHS also outreached to and communicated with the Tribal governments about the Frail Elder Waiver renewal application during the regularly scheduled Tribal consultation quarterly meeting on May 10, 2018. These meetings allow for direct discussion with Tribal government contacts about the HCBS waivers. The Tribal governments did not offer any comments or advice on the waiver renewal application.

J. **Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Bernstein
First Name:	Amy
Title:	Director, Community Based Waivers
Agency:	MassHealth
Address:	One Ashburton Place
Address 2:	5th Floor
City:	Boston
State:	**Massachusetts**
Zip:	02108
Phone:	(617) 573-1751 **Ext:** ☐ **TTY**
Fax:	(617) 573-1894
E-mail:	amy.bernstein@state.ma.us

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Vidler
First Name:	Lynn
Title:	

	Director of Home and Community Programs
Agency:	Executive Office of Elder Affairs
Address:	One Ashburton Place
Address 2:	5th floor
City:	Boston
State:	**Massachusetts**
Zip:	02108
Phone:	(617) 222-7589 **Ext:** ☐ **TTY**
Fax:	(617) 727-9368
E-mail:	lynn.vidler@state.ma.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Daniel Tsai
	State Medicaid Director or Designee
Submission Date:	Nov 7, 2018

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Tsai
First Name:	Daniel
Title:	Assistant Secretary and Director of MassHealth
Agency:	Executive Office of Health and Human Services
Address:	One Ashburton Place
Address 2:	11th Floor
City:	Boston
State:	**Massachusetts**

Zip: 02108

Phone: (617) 573-1600 **Ext:** ☐ **TTY**

Fax: (617) 573-1894

E-mail: Daniel.Tsai@state.ma.us

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Completed.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the states most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Below is the state's 11/7/18 response to the Appendix I-2-a questions from the Informal RAI received on 10/31/18. The response incorporates the following:

Informal RAI 10/4/18
MA Response #1 10/22/18
Informal RAI 10/31/18
MA Response #2 11/7/18

I-2a: Rate Determination Methods
4. The state failed to document or insufficiently documented the rate setting methods for each waiver service. The state does not sufficiently describe the negotiation process for waiver services with no comparable State Plan or EOHHS rate. There is no description of the rate negotiation oversight process between the Aging Services Access Points (ASAPs) and the contracted providers. The state references "leveraging the relative market power of the [Home Care Program] leading to efficiencies and economies of scale." It is unclear how the state leverages this program while negotiating their rates. Additionally, the state does not describe the oversight process for Transition Assistance Services and Environmental Accessibility Services, both of which are paid "according to the cost of the good."

a. Describe the rate negotiation oversight process for services with no comparable State Plan or EOHHS rate. How does the state ensure that these rates are sufficient? How does the state use the Home Care Program when setting rates?

MA Response #1:
For waiver services with no comparable State Plan or EOHHS rate, each ASAP negotiates the rates for the purchase of such services from contracted providers for all elders enrolled in the state-funded Home Care program, which includes the subset of elders participating in the Frail Elder Waiver. The Home Care Program, established under state law, serves up to 60,000 elders in the Commonwealth. Rates negotiated under the Home Care Program leverage the relative market power of the program, leading to efficiencies and economies of scale. In negotiating rates, ASAPs contract for one set of rates, without distinction between Home Care Program-funded services and services funded through the Frail Elder Waiver. Utilizing this approach ensures that the rates paid for Frail Elder Waiver services are at the market rate for similar services (i.e., the rates paid by ASAPs for Frail Elder Waiver services are the same rates paid under the Home Care Program). The state, through the Executive Office of Elder Affairs (EOEA), maintains oversight of Home Care Program/Frail Elder Waiver rates and ensures that rates are sufficient through regular and ongoing review and monitoring of the ASAP negotiated rates. This occurs through several mechanisms as described in Appendix I-2-a of the application and explained further below.

First, for Homemaker, Personal Care, and Supportive Home Care Aide services, which represent the majority of service needs and utilization in this waiver, EOEA reviews and approves each prospective service provider's proposed rate(s) prior to their contracting with any ASAP to provide services under the state Home Care Program/Frail Elder Waiver. This is accomplished through a Notice of Intent (NOI) process in which prospective service providers submit rate proposals to EOEA. EOEA's review of rate proposals ensures that providers' proposed rates are based on required rate development information (i.e., cost factors including but not limited to base wages, benefits, administrative overhead) and are sufficient, but not excessive. EOEA's NOI provider acceptance system electronically records and stores provider rate development information. Prospective providers whose proposed rates are not based on required rate development information or that are determined to be excessive are declined. Providers must remedy identified deficiencies and be approved by EOEA prior to contracting with any ASAP.

Second, for all services with no comparable State Plan or EOEA rate, each year EOEA reviews the contracted rates ASAPs have negotiated with service providers to ensure that across the Commonwealth, rates for each service are comparable while taking into consideration variation due to geographic area, workforce, cultural needs, or other relevant factors. Specifically, EOEA reviews, among other things, service costs and utilization, which EOEA uses to determine and monitor the average rate per service. EOEA's ongoing rate monitoring evidences little variation in rates by service across the state. Through the ASAP rate negotiation process, the state seeks to ensure optimal availability and provision of services while allowing ASAPs the flexibility to reflect geographic cost variables such as variations in transportation costs, labor costs, and ability to hire sufficient staff with appropriate language and cultural competence. Upon successful contract negotiation, the related service rates are entered into the Senior Information Management System (SIMS) and are available for EOEA review, reporting and analysis.

In addition, EOEA maintains regular, ongoing communication with the statewide ASAP network regarding all aspects of service delivery within the state Home Care Program/Frail Elder Waiver, including rates, workforce issues, provider changes (e.g., new providers, mergers, closings), and challenges such as difficulty securing service providers or staff. EOEA maintains oversight of, and close involvement with, these issues, including service rates and workforce issues, by holding monthly meetings with ASAP Executive Directors, separate monthly meetings with ASAP Fiscal Directors, as well as separate quarterly meetings with the ASAP Nurse Managers, ASAP Program Managers, ASAP Quality Managers and ASAP Contracts Managers. EOEA also holds quarterly meetings with the two trade associations involved with providers of Home Care Program/Frail Elder Waiver services. Through this extensive oversight and close involvement, the state, through EOEA, is able to ensure the sufficiency of rates.

Finally, the state also monitors utilization/provision of services according to waiver plans of care to ensure participants are receiving services as planned, i.e. as a further demonstration that rates are sufficient.

CMS Response #1:
Update Appendix I-2a to describe the development of rates for Homemaker, Personal Care, Supportive Home Aide Services, and other services with no comparable State Plan or EOEA rate using the language above describing EOEA oversight and leveraging of the Home Care Program.

MA Response #2:
This information has been added to the waiver application (Main Module—Optional).

b. Describe the oversight process for individuals receiving Transition Assistance and Environmental Accessibility Services.
i. How does the state ensure that the costs are reasonable?

MA Response #1
It is the responsibility of each ASAP to ensure that costs incurred for Transitional Assistance and Environmental Accessibility Adaptation services through the Frail Elder Waiver are reasonable. Consistent with practice in other Massachusetts HCBS waiver programs, the ASAPs consider the following factors to determine that such costs are reasonable:
• The amount of time required to complete the service/item;
• The degree of skill required to complete the service/item;
• The severity or complexity of the service/item;
• The lowest price charged or accepted from any payer for the same/similar service/item, including, but not limited to any shelf price, sale price, advertised price, or other price reasonably obtained by a competitive market for the service or item; and
• The established rates, policies, procedures, and practices of any other purchasing governmental unit in purchasing the same or similar services/items.
EOEA provides consultation to the ASAPs regarding any questions regarding these or other services. Should EOEA determine at any time through its analysis of service utilization and claims data that such costs do not appear to be reasonable, EOEA will provide guidance to the ASAPs through regular communication with ASAP Fiscal Directors, Program Managers, and other staff, or through written program instruction.

CMS Response #1:
The state adequately describes their oversight method for Transition Assistance and Environmental Accessibility Services, which is consistent with other waiver programs in the state. Update Appendix I-2a to include the above information. We request no additional information.

MA Response #2:
This information has been added to the waiver application (Main Module—Optional).

ii. Does the state require multiple bids from multiple providers?

MA Response #1:
No.

CMS Response #1:
The state specifies that they do not require multiple bids for Transition Assistance / Environmental Accessibility Services, but examines “The lowest price charged or accepted from any payer for the same/similar service/item, including, but not limited to any shelf price, sale price, advertised price, or other price reasonably obtained by a competitive market for the service or

item" when determining if a cost is reasonable.

CMS requests that the state respond to the follow-up questions below and update the waiver application with the following information:
a. How does the state track the above information?

MA Response#2:
The state tracks the cost of Transition Assistance and Environmental Accessibility Services on an annual basis through claims data that demonstrates cost and utilization of these services.

This information has been added to the waiver application (Main Module—Optional).

b. How does the state ensure that the cost of services are reasonable within the market without obtaining multiple bids for the service or capping payment with a maximum allowable cost?

MA Response #2:
ASAPs must follow EOEA written guidance for determining payments for services. The state's annual review of claims data has indicated that cost and utilization of these services has been, and remains, reasonable. The state has determined that imposing a maximum allowable cost is not necessary.

This information has been added to the waiver application (Main Module—Optional).

iii. Who is responsible for making the final decision on whether the service is reasonable?

MA Response #1:
All waiver services, including Transitional Assistance and Environmental Accessibility services, must be authorized in the waiver Plan of Care. The Case Manager is responsible for making such authorization based on the needs addressed through the person-centered planning process. The Plan of Care is reviewed by the ASAP RN and Supervisor. When potential purchases for Transitional Assistance or Environmental Accessibility services are more than standard purchase authorizations, they are reviewed by the ASAP Director of Client Services and/or Fiscal Manager.

CMS Response #1:
Update the waiver application to include this information.

MA Response #2:
This information has been added to the waiver application (Main Module—Optional).

5. The state failed to document or insufficiently documented how the Medicaid agency solicits public comments on rate determination methods. EOHHS is required to complete a public comment process. This includes public hearings. The state only applies this public comment process to services for which there is a comparable Medicaid State Plan rate. The state does not describe public comment processes for the other defined rate methodologies.
a. How does the state ensure stakeholders have the opportunity for public comment for services that do not have a comparable State Plan rate? What methods does the state use to ensure that participants and providers have the opportunity to voice concerns over rate determination methods?

MA Response #1:
The state ensures that stakeholders have opportunity to voice concerns over rates and rate determination methods by maintaining regular communication with both provider and participant stakeholders. At the provider level, EOEA holds quarterly meetings with provider trade associations that are a platform to discuss all aspects of service delivery within the state Home Care Program and Frail Elder Waiver, including rates and workforce issues.

Additionally, opportunity for public comment regarding rate determination methods is provided formally through the waiver public comment process. As described in the Main Module, Massachusetts outreaches broadly to the public and to interested stakeholders to solicit input on the waiver application—which includes the rate determination methods—by posting the waiver application and a summary of major changes to MassHealth's website, issuing public notices in multiple newspapers, and emailing key advocacy organizations as well as the Native American tribal contacts directly. The newspaper notices and email provide the link to the MassHealth website that includes the draft application, the public comment period, information regarding a public listening session at which comments can be submitted orally or in writing, and, for anyone wishing to send comments, both email and mailing addresses.

CMS Response #1:
Update Appendix I-2-a to include the above information describing the public comment process specific to rate determination.

MA Response #2:
This information has been added to the waiver application (Main Module—Optional).

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   The Executive Office of Elder Affairs-While EOEA is organized under EOHHS & subject to its oversight authority, it is a separate state agency established by & subject to its own enabling legislation.
   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Executive Office of Health and Human Services (EOHHS) is the single state agency for administration of the Medicaid program in Massachusetts. MassHealth, the medical assistance unit within EOHHS, oversees the administration and day-to-day operation of the Frail Elder Waiver ("FEW" or "Waiver") by the Executive Office of Elder Affairs (EOEA), a state agency within and subject to the oversight authority of EOHHS. The State Medicaid Director has ultimate oversight authority over waiver operational activities.

MassHealth and EOEA developed an Interagency Service Agreement that specifies the functions of MassHealth and EOEA related to operation of the Waiver. Using several management functions, the Medicaid Director, MassHealth staff and Executive Office of Elder Affairs staff collaborate in the operation of the waiver program. Some of these oversight activities include:
-Regular Secretariat-level meetings related to Long Term Services and Supports oversight are typically monthly meetings convened by the Secretary of Health and Human services and including the Secretary of Elder Affairs, the Assistant Secretary for MassHealth, and senior leadership staff for the purpose of overseeing the governance of the Office of Long Term Services and Supports, including the SCO program, and coordination between long term services and supports delivered under the Medicaid State Plan and the waiver.

-Regular Waiver Oversight meetings. Staff of the MassHealth Community Waiver Unit and the EOEA staff operating the waiver meet at least monthly, and on an ad hoc basis to review waiver operations, discuss quality goals and measurement, and identify needs for any changes to the waiver.
-Enrollment and expenditure reporting. The Commonwealth is required to report enrollment and expenditure data for the Waiver to CMS through the submission of CMS-372 reports. MassHealth's Director of Community Based Waivers coordinates this activity with EOHHS staff from Elder Affairs, Information Technology/Data Warehouse, the MassHealth Office of Long Term Services and Supports Coordinated Care Unit, Budget, and Revenue to ensure appropriate coding for claims and enrollee identification are used and reports are accurate. Reports are used for monitoring as well as for federal reporting.
-Regulations and policy implementation. MassHealth regulations at 130 CMR 519.007(B) describe eligibility for the Waiver. The MassHealth Operations (MHO) unit ensures that the eligibility system (MA-21) has logic and coding to properly determine eligibility for the Waiver program as well as procedures for accepting clinical determinations and processing financial information for eligibility determinations.
-Systems validation reports. The Evaluation unit of MHO performs random reviews of all MA-21 results to determine accuracy and examine supporting financial documentation. Error rates are determined and inaccuracies are referred to MHO eligibility staff for resolution.
-Staff of the MassHealth Community Waiver Unit participate, as appropriate, in EOEA workgroup activities associated with establishing quality indicators, policy and programmatic change contemplated to ensure appropriate waiver operation and alignment with CMS policies, rules and regulations.
- EOEA and the MassHealth Office of Long Term Services and Supports Coordinated Care Unit meet regularly to discuss operation of the waiver. Topics discussed include Senior Care Options (SCO), operational performance, contract management, quality reporting, and changes to be made in waiver policy.
- Executive Office of Elder Affairs Leadership Team Meetings – The Executive Office of Elder Affairs regular leadership team meetings include participation from the MassHealth Office of Long Term Services and Supports, the EOEA Home and Community Programs staff, and EOEA programmatic and finance leadership. This meeting includes key issues related to the operation of the ASAP network and the SCO organizations.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the**

Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Frail Elder Waiver participants aged 65 and older may choose to enroll in Senior Care Options, a managed care delivery system, to receive their Waiver services through a MassHealth-contracted managed care organization known as a Senior Care Organization ("SCO"). MassHealth contracts with SCOs for certain waiver operational and administrative functions, as indicated in Appendix A-7. SCO organizations are responsible for continuously monitoring clinical status, redetermination of level of care, conducting needs assessments, developing and monitoring person-centered service plans, providing interdisciplinary care management, and reporting participant data to MassHealth. In addition SCO organizations deliver qualified provider enrollment and quality assurance and improvement activities. SCOs have contractual relationships with ASAPs for case management of community based long term services and supports of SCO-enrolled individuals receiving Waiver services. These contracted case managers participate on the SCO's interdisciplinary care team.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

The Executive Office of Elder Affairs contracts with 26 nonprofit agencies called Aging Services Access Points (ASAPs) in the operation of the Waiver. As EOEA's agents, the ASAPs are responsible for assessing clinical eligibility, determining level of care, conducting needs assessments, developing and monitoring person-centered service plans, providing interdisciplinary care management, and reporting participant data to EOEA. Aging Services Access Points (ASAPs), which are frequently also the local Area Agency On Aging, are designated by and under contract to the Executive Office of Elder Affairs. Massachusetts General Laws c.19a § 4b describes the functions of ASAPs. ASAPs contract with Elder Affairs to: purchase community-based long term services and supports for participants, and provide Adult Protective Services, nutrition services, Information and Referral, and Case Management, as well as coordinate and authorize the delivery of Home Care Program Services, and provide clinical screening for: nursing facility care, HCBS waiver eligibility, and community-based long term services and supports. Each agency is organized to plan, develop, and implement the coordination and delivery of community-based long term services and supports.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Executive Office of Elder Affairs is responsible for oversight of all ASAP activities, including identifying and analyzing trends related to the operation of the Waiver and determining strategies to address quality-related issues. EOEA is responsible for ensuring that remediation strategies are implemented within appropriate timelines if/when any issues are discovered related to ASAPs' operation of the waiver program.

   The MassHealth Office of Long Term Services and Supports (LTSS) oversees the Senior Care Options program, and is responsible for ensuring that remediation strategies are implemented within appropriate timelines if/when any issues are discovered related to SCOs' contracted waiver operational and administrative functions. LTSS, in conjunction with EOEA, provides guidance and direction to SCOs. If areas of noncompliance are identified, LTSS requires SCOs to submit corrective action plans (CAPs) as appropriate, and monitors the SCOs' implementation of CAPs to ensure their effectiveness.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The Executive Office of Elder Affairs conducts ongoing on-site reviews and desk audits of each ASAP. These audits include a review of all waiver functions the ASAPs perform on behalf of EOHHS. As part of the audit process, a random sample of waiver participants is selected and both paper and electronic records are reviewed for adherence to identified compliance measures and quality indicators. In addition, annual reporting by the ASAP to EOEA ensures they are meeting the measures for all waiver participants. EOEA conducts key informant interviews to learn about agency practices and procedures. Summary findings of any review conducted by EOEA are made available to MassHealth on an as-needed basis.

   The MassHealth Office of Long Term Services and Supports (LTSS) conducts audits of each SCO annually, which includes review of Level of Care re-evaluations, qualified provider enrollment, and quality assurance/quality improvement activities as they relate to waiver participants. As part of the audit process, a random sample of waiver participants is selected and reviewed for adherence to identified compliance measures and quality indicators. In addition, SCOs are required to report waiver quality indicator data no less than twice a year to LTSS. LTSS staff work in tandem with EOEA to analyze quality indicators to determine if the SCOs are meeting the measures for all SCO-enrolled waiver participants. If areas of noncompliance are identified, LTSS will institute corrective action plans for a SCO.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☐	☐
Waiver enrollment managed against approved limits	☑	☐	☐

Waiver expenditures managed against approved levels	☑	☐	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☑	☐	☐
Utilization management	☑	☐	☐
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☐	☑
Establishment of a statewide rate methodology	☑	☐	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
AA 1. EOEA and MassHealth worked collaboratively with ASAPs and SCOs to ensure systematic and continuous data collection and analysis of the ASAP and SCO functions, as evidenced by timely and accurate submission of quality data reports. Numerator: Number of ASAP and SCO quality reports that were accurate, on time, and in the correct format Denominator: Number of ASAP and SCO reports due

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
ASAP quality reporting to EOEA and SCO reporting to LTSS SCO Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and SCOs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

AA 2. EOEA and MassHealth oversaw, through annual data analysis, ASAP and SCO performance of waiver functions, as described in the waiver application. Numerator: Number of performance measures for which EOEA analyzed data Denominator: Number of performance measures in the waiver application

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA annual quality reporting on performance measures

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

☐ **Continuously and Ongoing**
☐ **Other** Specify:

Performance Measure:
AA 3. Participants were supported by competent and qualified case managers, in accordance with state requirements. Numerator: Number of Case Managers that met qualification standards Denominator: Number of Case Managers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
ASAP quality reporting to EOEA and SCO reporting to LTSS SCO Unit

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and SCOs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA 4. An annual reevaluation of level of care was completed on a timely basis for each waiver participant. Numerator: Number of waiver participants whose level of care evaluation was conducted in the past year Denominator: Number of waiver participants who were due for a level of care redetermination

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):

Other
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ Aged or Disabled, or Both - General					
	☑	Aged	65		☑
	☑	Disabled (Physical)	60	64	
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Not applicable. There is no maximum age limit.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a

State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  [ ]

  The cost limit specified by the State is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

      [ ]

    - ( ) **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

  - ( ) **The following percentage that is less than 100% of the institutional average:**

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	19200

Year 2	19400
Year 3	19600
Year 4	19800
Year 5	20000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The waiver provides for the entrance of all eligible persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (●) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (•) **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- (•) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- [x] **A special income level equal to:**

Select one:

- (•) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**
○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-3: Post-Eligibility Treatment of Income (2 of 4)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the State plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional State supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage: [ ]
  - ( ) **Other standard included under the State Plan**

    Specify:

    [ ]
- ( ) **The following dollar amount**

  Specify dollar amount: [ ] If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

  [ ]
- ( ) **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- (●) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**

- (●) **The special income level for institutionalized persons**
- ( ) **A percentage of the Federal poverty level**

  Specify percentage:
- ( ) **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ( ) **The following formula is used to determine the needs allowance:**

  Specify formula:
- ( ) **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- (●) **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The State does not establish reasonable limits.**
- ( ) **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level (s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Waiver services must be scheduled on at least a monthly basis. The participant's case manager will be responsible for monitoring on at least a monthly basis when the participant does not receive scheduled services for longer than one month (for example when absent from the home due to hospitalization). Monitoring may include face-to-face or telephone contact with the participant and may also include collateral contact with formal or informal supports. These contacts will be documented in the participant's case record.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

Aging Services Access Point (ASAPs) Registered Nurses are responsible for performing initial level of care evaluations for all waiver participants and for performing annual level of care reevaluations for waiver participants served by the ASAP. For waiver participants enrolled in Senior Care Options, Senior Care Organizations (SCOs) Registered Nurses are responsible for performing annual level of care reevaluations only.

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurses (RN) licensed in Massachusetts

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Participants must meet the clinical eligibility criteria for nursing facility services as outlined in 130 CMR 456.409 (MassHealth Nursing Facility regulations that describe the requirements for medical eligibility for nursing facility services). Functional impairment level and need criteria are assessed in accordance with Home Care Program regulations found at 651 CMR 3.03 (Department of Elder Affairs Home Care Program regulations that describe home care program eligibility). MassHealth Provider Bulletins and Elder Affairs Program Instructions or Information Memoranda may be issued from time to time to further clarify regulatory requirements.

Registered nurses employed by the ASAPs perform the clinical evaluations of potential participants with an in-person assessment utilizing a standard assessment tool, the Comprehensive Data Set (CDS), which includes, in its entirety, the Minimum Data Set-Home Care (MDS-HC) or successor tool in use by the state. The CDS assessment is automated in the Senior Information Management System (SIMS).

The participant's annual redetermination will utilize the core elements of same tool (i.e. MDS-HC).

For waiver participants enrolled in Senior Care Options, Senior Care Organizations (SCOs) Registered Nurses are responsible for performing level of care reevaluations. Participants are assessed using the Minimum Data Set-Home Care (MDS-HC).

Clinical eligibility for all participants is determined using the current clinical criteria for nursing facility services.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level

of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The ASAP RN conducts an in-person assessment of the applicant/participant for both initial as well as annual reevaluation of level of care, and completes the CDS assessment tool. The in-person assessment is generally conducted in the elder's home, but may be conducted in an alternative location such as a nursing facility. Additional information may be obtained from other sources including any case manager or other providers.

The ASAP RN enters these clinical determinations and supporting information into the participant's record in SIMS.

For participants enrolled in a Senior Care Organization (SCO), the SCO RN conducts an in-person reevaluation of the participant and completes the MDS-HC assessment tool. The in-person assessment is generally conducted in the participant's home, but may be conducted in an alternative location. Additional information may be obtained from other sources including the case manager or other provider. The MDS-HC is submitted electronically to MassHealth and reviewed by nurses employed by LTSS for confirmation that the participant continues to meet level of care requirements.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

Timely reevaluation of level of care completed by the appropriate ASAP or SCO nurse is ensured by the use of an automated information system. The automated information system tracks the date of the individual's level of care evaluation and the due date for the next re-evaluation. Through the use of management reports ASAP and SCO staff are provided with the data needed to ensure timely completion of reevaluation. State monitoring is conducted on all

records to ensure that re-evaluations have been conducted in accordance with all requirements.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Determinations of level of care are maintained in electronic records as part of the Senior Information Management System (SIMS). Reevaluations of level of care are maintained in a consistent manner either by the ASAP or a SCO, depending on the service delivery system chosen by the Participant. Paper records are maintained for each waiver participant by the relevant ASAP or SCO, in accordance with 808 CMR 1.00 (The State's Division of Purchased Services regulations that describe the contract compliance, financial reporting and auditing requirements applicable to state procurements of human and social services.) and EOEA-PI-04-08.
For SCO enrolled participants, reevaluation assessments are uploaded electronically through the EOHHS Virtual Gateway. Once level of care is confirmed the data transfers to the EOHHS data warehouse. The reevaluation assessments uploaded by the SCO plans are maintained electronically in the MassHealth data warehouse indefinitely and the data is retrievable.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC a1. Applicants' initial clinical eligibility was assessed by an RN within 10 business days of identifying their need for the waiver program. Numerator: Number of waiver applicants whose initial clinical eligibility was assessed within 10 business days of identifying their need for the waiver program Denominator: Number of waiver applicants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
LOC c1. Applicants' initial level of care evaluation was completed by an RN, as evidenced by a signature and credentials on the approved evaluation tool. Numerator: Number of applicants whose initial level of care evaluation was completed by an RN, as evidenced by a signature and credentials on the approved evaluation tool Denominator: Number of assessed applicants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC c2. The reevaluation of level of care was completed using an approved assessment tool. Numerator: Number of waiver participants whose level of care was determined using an approved assessment tool Denominator: The number of waiver participants who had an annual level of care redetermination completed

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC c3. RNs cited the regulatory requirements on the approved tool to support applicants' initial level of care determinations. Numerator: Number of applicants with appropriate regulatory requirements cited in support of initial level of care determinations Denominator: Number of assessed applicants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging

Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Once initial clinical eligibility has been determined, the case manager delivers a Recipient Choice Form to the elder (or legal representative) either in person or by mail. This form includes written notification that the elder has been determined eligible for nursing facility services and offers the elder the opportunity to choose between community-

based or nursing facility services. The participant indicates his/her preference on the Recipient Choice Form. The signed and dated form is maintained by the ASAP, for all waiver participants, in the participant record.

If the elder chooses to receive community-based services, the case manager informs the elder of the services available under the waiver as part of the needs assessment and service plan development process.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Recipient Choice Form is maintained in the client record at the ASAP office.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The Executive Office of Elder Affairs (EOEA) and its contractors have developed multiple approaches to promote and ensure access to the waiver by Limited English Proficient persons. EOEA has made waiver documents, such as eligibility notices and information regarding appeal rights, available in a number of languages. ASAPs and SCOs are required to ensure the provision of services that are accessible to current and potential consumers. Accessible services are defined as those that address geographic, physical, and communication barriers so that consumers can be served according to their needs. ASAPs conduct outreach in their communities with brochures and other materials in languages appropriate to their geographic service area. ASAPs also work collaboratively with multicultural community organizations that provide social services to identify individuals and families who may be eligible for services from EOEA, including waiver program services. SCOs conduct outreach, as allowed by CMS and EOHHS, in a manner that ensures accessibility.

ASAPs/SCOs must ensure that ASAP/SCO employees are capable of speaking directly with participants in their primary language. When this is not possible, they must arrange for interpreting services by either a paid interpreting service or through an individual, such as a family member, designated by the participant. These entities are further required to assess the linguistic and cultural profile of the communities in which they provide services and identify populations not currently being served by linguistically or culturally appropriate staff of either the entity or waiver service providers. In addition, each ASAP and SCO must ensure access to TTY services or Telecommunications Relay Services.

EOEA promotes access to waiver services by working to build capacity among service providers to become more culturally responsive in the delivery of services. Contracting entities use information gathered in the linguistic and cultural profile of their communities to evaluate waiver service providers and to inform them of gaps in linguistic competence. In turn, service providers address identified gaps in multiple ways, including outreach efforts, hiring of bilingual and bicultural staff, providing information in the primary languages of the participants and families receiving services, and developing working relationships with other multicultural community organizations in their communities.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Alzheimer's/Dementia Coaching
Statutory Service	Home Health Aide
Statutory Service	Homemaker
Statutory Service	Personal Care
Statutory Service	Respite
Other Service	Chore

Other Service	**Companion**
Other Service	**Complex Care Training and Oversight (formerly Skilled Nursing)**
Other Service	**Enhanced Technology/Cellular Personal Emergency Response System (PERS)**
Other Service	**Environmental Accessibility Adaptation**
Other Service	**Evidence Based Education Programs**
Other Service	**Goal Engagement Program**
Other Service	**Grocery Shopping and Delivery**
Other Service	**Home Based Wandering Response Systems**
Other Service	**Home Delivered Meals**
Other Service	**Home Delivery of Pre-packaged Medication**
Other Service	**Home Safety/Independent Evaluations (formerly Occupational Therapy)**
Other Service	**Laundry**
Other Service	**Medication Dispensing System**
Other Service	**Orientation and Mobility Services**
Other Service	**Peer Support**
Other Service	**Senior Care Options (SCO)**
Other Service	**Supportive Day Program**
Other Service	**Supportive Home Care Aide**
Other Service	**Transitional Assistance**
Other Service	**Transportation**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Habilitation

Alternate Service Title (if any):

Alzheimer's/Dementia Coaching

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Alzheimer's/Dementia Coaching (Habilitation Therapy) is a service designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Alzheimer's/Dementia Coaching creates and maintains a positive experience for a person experiencing the effects of a dementia related illness. The objective is to provide education and support to the consumer and caregiver and to provide suggestions to modify elements of the environment that may exacerbate the symptoms of the disease. Habilitation Coaches provide knowledge and expertise to caregivers (and the person with the disease when appropriate) in understanding the disease process and pitfalls to avoid, as well as techniques of communication, behavior management, structuring the environment, creating therapeutic activities and planning for future care needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Agency	Alzheimer's/Dementia Coaching agencies
Individual	Qualified individual providers of Alzheimer's/Dementia Coaching
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:
Agency
Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*

In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following:
- Registered Nurse
- Licensed Independent Clinical Social Worker
- Licensed Certified Social Worker w/one year of experience working with person with dementia/related illness
- Occupational Therapist
- or other similar professional licensure.

Certificate *(specify):*
Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association. Agencies may apply to EOEA for a waiver in order to have an individual who has been trained in Habilitation Therapy by the Alzheimer's Association conduct training for additional staff.

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:
Agency

Provider Type:
Alzheimer's/Dementia Coaching agencies

Provider Qualifications

License *(specify):*

In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following:
- Registered Nurse
- Licensed Independent Clinical Social Worker
- Licensed Certified Social Worker w/one year of experience working with person with dementia/related illness
- Occupational Therapist
- or other similar professional licensure.

Certificate *(specify):*
Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association. Agencies may apply to EOEA for a waiver in order to have an individual who has been trained in Habilitation Therapy by the Alzheimer's Association conduct training for additional staff.

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:
Individual

Provider Type:
Qualified individual providers of Alzheimer's/Dementia Coaching

Provider Qualifications

License *(specify):*

In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following:
- Registered Nurse
- Licensed Independent Clinical Social Worker
- Licensed Certified Social Worker w/one year of experience working with person with dementia/related illness
- Occupational Therapist
- or other similar professional licensure.

Certificate *(specify):*
Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association

Other Standard *(specify):*
Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Individual Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Alzheimer's/Dementia Coaching

Provider Category:
Agency

Provider Type:
Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*
In addition to the certification requirements listed below, Alzheimer's Dementia Coaching must be performed by a professional with a valid Massachusetts license for any of the following:
- Registered Nurse
- Licensed Independent Clinical Social Worker
- Licensed Certified Social Worker w/one year of experience working with person with dementia/related illness
- Occupational Therapist
- or other similar professional licensure.

Certificate *(specify):*
Services must be performed by an individual trained in Habilitation Therapy by the Alzheimer's Association. Agencies may apply to EOEA for a waiver in order to have an individual who has been trained in Habilitation Therapy by the Alzheimer's Association conduct training for additional staff.

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Home Health Aide

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home Health Aides provide healthcare assistance and help with personal care for participants whose care needs exceed the scope of Personal Care worker expertise and training as specified in Elder Affairs Personal Care Guidelines. Participants appropriate for Home Health Aide services have specialized care needs that waiver Personal Care service workers are not qualified to provide, which may include but are not limited to: inability to transfer more than 50% of their body weight, have extensive mobility limitations, require the use of a mechanical lift, require special skin care, require ostomy care or have other unstable medical conditions. Services are provided under the supervision of an RN and include: personal care, including incontinence care; assistance with ambulation and transfers; medication cueing and reminders; activities that support the participant's person-centered goals; and routine care of prosthetic and orthotic devices.

Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved State Plan. Home health aide services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services in the State Plan. The difference from the State Plan is as follows: Agencies that provide Home Health Aide services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28. In addition, unlike State Plan Home Health benefits, waiver Home Health Aide services may be provided when the waiver participant is not receiving other skilled nursing or therapy services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Agency
Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*
Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.
Certificate *(specify):*
Individuals employed by the agency providing homemaker services must have one of the following:

-Certificate of Home Health Aide Training; or
-Certificate of Certified Nurse's Aide Training
Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their jobs, including handling emergency situations and established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual home health aides employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications
Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C 1/C 3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Agency
Provider Type:
Homemaker/Personal Care Agencies
Provider Qualifications
License *(specify):*
Supervision of Home Health Aides must be provided by a Registered Nurse with a valid Massachusetts license.
Certificate *(specify):*
Individuals employed by the agency providing homemaker services must have one of the following:

-Certificate of Home Health Aide Training; or
-Certificate of Certified Nurse's Aide Training
Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their jobs, including handling emergency situations and established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual home health aides employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.
Verification of Provider Qualifications
Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 2 years

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Homemaker service includes assistance with: shopping, menu planning, laundry, and the performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker/Personal Care Agencies
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individuals employed by the agency providing homemaker services must have one of the following:

-Certificate of Home Health Aide Training
-Certificate of Nurse's Aide Training
-Certificate of 40-Hour Homemaker Training

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual homemakers employed by the agency are able to:

perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individuals employed by the agency providing homemaker services must have one of the following:

-Certificate of Home Health Aide Training
-Certificate of Nurse's Aide Training
-Certificate of 40-Hour Homemaker Training

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual homemakers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
A range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing and supervision to prompt the participant to perform a task. Such

assistance may include assistance in bathing, dressing, personal hygiene and other activities of daily living, and medication reminders in accordance with Elder Affairs' Personal Care Guidelines. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the care plan, this service may also include such housekeeping chores as bed-making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health or welfare of the individual, rather than the individual's family. Personal care services may be provided on an episodic or on a continuing basis.

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State Plan. Personal care under the waiver may include supervision and cueing of participants. The waiver service is an agency model of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individuals employed by the agency providing personal care services must have one of the following:

-Certificate of Home Health Aide Training
-Certificate of Nurse's Aide Training
-Certificate of 60-Hour Personal Care Training

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Agency

Provider Type:
Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individuals employed by the agency providing personal care services must have one of the following:

-Certificate of Home Health Aide Training
-Certificate of Nurse's Aide Training
-Certificate of 60-Hour Personal Care Training

Other Standard *(specify):*

Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Waiver services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Federal Financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.
Respite Care may be provided to relieve informal caregivers from the daily stresses and demands of caring for a participant in efforts to strengthen or support the informal support system. In addition to respite care provided in the participants home or private place of residence, Respite Care services may be provided in the following locations:

-Respite Care in an Adult Foster Care Program provides personal care services in a family-like setting. A provider must meet the requirements set forth by MassHealth and must contract with MassHealth as an AFC provider.
-Respite Care in a Hospital is provided in licensed acute care medical/surgical hospital beds that have been approved by the Department of Public Health.
-Respite Care in a Rest Home provides residential care for clients in a supervised, supportive and protective environment. A Rest Home must be licensed by the Department of Public Health.
-Respite Care in a Skilled Nursing Facility provides skilled nursing care; rehabilitative services such as physical, occupational, and speech therapy; and assistance with activities of daily living such as eating, dressing, toileting and bathing. A nursing facility must be licensed by the Department of Public Health.
-Respite Care in an Assisted Living Residence provides personal care services by an entity certified by the Executive Office of Elder Affairs.
-Respite Care in an Adult Day Health program provides an organized program of health care and supervision, restorative services, and socialization for elders who require skilled services or physical assistance with activities of daily living. Nutrition and personal care services are also provided to participants. Adult Day Health programs must be approved for operation by MassHealth.

Respite services provided in an Adult Foster Care Program, Hospital, Rest Home, Skilled Nursing Facility or Assisted Living Residence may include the costs of room and board.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Foster Care
Agency	Assisted Living Residence
Agency	Skilled Nursing Facility
Agency	Adult Day Health
Agency	Hospital
Agency	Rest Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An organization which meets the requirements of 130 CMR 408.000 (MassHealth Adult Foster Care regulations that define provider eligibility requirements and program rules) and that contracts with MassHealth as the provider of Adult Foster Care.

Verification of Provider Qualifications

Entity Responsible for Verification:

MassHealth

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Residence

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by EOEA in accordance with 651 CMR 12.00 (EOEA regulations describing the certification procedures and standards for Assisted Living Residences in Massachusetts)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

EOEA

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Skilled Nursing Facility

Provider Qualifications

License *(specify):*

Licensed by the Department of Public Health in accordance with 105 CMR 153.00 (Department of Public Health Licensure Procedure and Suitability Requirements for long-term care facilities in Massachusetts)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Health

Provider Qualifications

License *(specify):*
Licensed by the Department of Public Health in accordance with 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs)

Certificate *(specify):*

Other Standard *(specify):*
An organization that meets the requirements of 105 CMR 158.00 (Department of Public Health Licensure of Adult Day Health Programs) and that contracts with MassHealth as a provider of Adult Day Health services.

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Hospital

Provider Qualifications

License *(specify):*
Licensed by the Department of Public Health in accordance with 105 CMR 130.00 (Department of Public Health Hospital Licensure regulations that describe the standards for the maintenance and operation of hospitals in Massachusetts)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DPH

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Rest Home

Provider Qualifications

License *(specify):*

Licensed by the Department of Public Health in accordance with 105 CMR 153.00 (Department of Public Health Licensure Procedure and Suitability Requirements for long-term care facilities in Massachusetts)

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DPH

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services needed to maintain the home in a clean, sanitary and safe environment. This service includes minor home repairs, maintenance, and heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:
Agency
Provider Type:
Chore Provider Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Companion

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. This service may include transportation for the participant when authorized through the care plan. The provision of companion services does not entail hands-on nursing or ADL care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a therapeutic goal in the service plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Companion Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Companion

Provider Category:
Agency

Provider Type:
Companion Provider Agencies

Provider Qualifications

License *(specify):*
If the worker will be providing transportation they must have a valid Driver's License

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.
Adherence to Continuous QI Practices:

Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include:
-Client Not at Home Policy and Client Emergency in the Home Policy.
When transportation is provided: Providers must have policies and procedures that include:
-Vehicle safety and maintenance
-Assisting passengers on/off vehicles and from door to door
-Ensuring drivers have current licenses as required and current Auto Insurance

In addition, providers shall ensure that individuals employed by the agency to provide companion service are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Complex Care Training and Oversight (formerly Skilled Nursing)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Complex Care Training and Oversight is a periodic, episodic service that includes medication management (e.g., filling medication cassettes) as well as development and ongoing management and evaluation of the participant's Home Health Aide Plan of Care, for purposes of monitoring the participant's underlying conditions or complications to ensure the unskilled care is successfully addressing the participant's needs.

Complex Care Training and Oversight services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license. Agencies that provide Complex Care Training and Oversight services under the waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Complex Care Training and Oversight (formerly Skilled Nursing)

Provider Category:
Agency
Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Complex Care Training and Oversight services must be performed by a Registered Nurse, or a Licensed Practical Nurse under the supervision of a Registered Nurse. All nurses must have a valid Massachusetts license.

Certificate *(specify):*

Other Standard *(specify):*

Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55(Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Complex Care Training and Oversight (formerly Skilled Nursing)

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care Agencies

Provider Qualifications

License *(specify):*

Complex Care Training and Oversight services must be performed by a Registered Nurse, or a Licensed Practical Nurse under the supervision of a Registered Nurse. All nurses must have a valid Massachusetts license.

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55(Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Enhanced Technology/Cellular Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Enhanced Technology/Cellular Personal Emergency Response System (PERS) provides personal emergency response service. Cellular PERS functionality includes:
• Cellular capacity that is built into the PERS unit, allowing emergency calls to go to the monitoring center by converting the signal to cellular.
• The consumer presses the help button and there is immediate response 24/7 via 2-way voice connection through the PERS device.

Cellular PERS may also include fall detection technology.

Agencies that provide Enhanced Technology/Cellular PERS under the waiver are not required to meet the requirements for participation in Medicaid, as provided in 130 CMR 409.00 (MassHealth Durable Medical Equipment regulations that describe the provider eligibility requirements and program rules). This service does not duplicate services available through the State Plan. Participants may not receive Enhanced Technology/Cellular Personal Emergency Response System (PERS) at the same time that they receive State Plan PERS.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Enhanced Technology/Cellular Personal Emergency Response System (PERS)

Provider Category:
Agency

Provider Type:
Personal Emergency Response Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include:
- Maintenance of 24-hour monitoring station, including communication protocols for the hearing impaired and access to interpreter services in emergencies; and
- Equipment testing.

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years
For those agencies unable to be monitored via on-site visit due to geographical distance, the ASAP will conduct periodic random testing; at a minimum of every 6 months for waiver participants.

Appendix C: Participant Services

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an approved adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptation Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptation

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptation Agencies

Provider Qualifications

License *(specify):*

If the scope of work involves home modifications, agencies and individuals employed by the agencies must possess any appropriate licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc)

Certificate *(specify):*

Other Standard *(specify):*

Any not-for-profit or proprietary organization that contracts with the ASAP as such and successfully demonstrates, at a minimum, the following: Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

Confidentiality:

Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Evidence Based Education Programs

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Evidence Based Education Programs provide participants with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS and depression, to better manage/prevent falls, or to appropriately manage/assist their caregivers in provision of their care (eg., for individuals with dementia). All Evidence Based Education Programs are provided either as peer-facilitated self-management workshops that meet weekly for six or eight weeks or as 1:1 interventions with a trained coach. They promote participant's active engagement to undertake self-management of chronic conditions by teaching behavior management and personal goal-setting. Topics include diet, exercise, medication management, cognitive and physical symptom management, problem solving, relaxation, communication with healthcare providers and dealing with difficult emotions. Each course requires trained facilitators who adhere to prescribed, evidence-based and validated modules for each workshop. Workshops are broken down to include training in: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) optimal nutrition, 6) decision making, and 7) how to evaluate new treatments. Classes and/or 1:1 trainings are highly interactive, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.
Evidence Based programs may include but are not limited to: Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (Spanish CDSMP), Arthritis Self-Management Program (English and Spanish), Chronic Pain Self-Management program, Diabetes Self-Management Program (English and Spanish), Positive Self-Management Program (HIV/AIDS), A Matter of Balance falls prevention, Healthy Ideas (identifying depression empowering activities for seniors), Healthy Eating for Successful Living, Savvy Caregiver, Powerful Tools for Caregivers, Enhanced Wellness, and Fit for Your Life.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Participants may enroll in no more than two courses per calendar year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Evidence Based Education Program provider agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Evidence Based Education Programs

Provider Category:
Agency
Provider Type:
Evidence Based Education Program provider agencies
Provider Qualifications

License *(specify):*
Must be under license maintained by the Healthy Living Center of Excellence or Self-Management Resource Center (formally known as the Stanford Patient Education Research Center)
Certificate *(specify):*
Certificate of good standing from the Healthy Living Center of Excellence
Other Standard *(specify):*
Agency provider must employ staff who have been trained and certified by the Healthy Living Center of Excellence or by the Self-Management Resource Center, and must demonstrate:
1. Leadership
2. Delivery infrastructure
3. Partnerships
4. Centralized and coordinated logistical processes
5. Business planning and financial sustainability
6. Quality assurance and fidelity to the model of licensure and quality standards set forth by the evidence-based program developer.
Education, Training, Supervision:
Providers must ensure training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.
Individual staff who implement Evidence Based Education Program workshops and 1:1 trainings must complete 2 hours of continuing education (in person or webinar) annually with the Healthy Living Center for Excellence or the Self-Management Resource Center.
Adherence to continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.
Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.
Responsiveness:
Providers must be able to initiate services with little or no delay.
Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L.c.66A. (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Goal Engagement Program

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Goal Engagement program is a set of highly individualized, person-centered services that use the strengths of the waiver participant to improve her/his safety and independence. Goal Engagement Program services engage participants to identify and address their goals related to increasing functional independence, improving safety, decreasing depression and improving motivation, including addressing barriers to achieve and maintain maximum functional independence in their daily lives.

Participants receive a structured set of home visits conducted by a multidisciplinary team consisting of an Occupational Therapist (OT), a Registered Nurse (RN), and a home repair specialist. The participant and OT work together to identify areas of concern using a standardized assessment tool. Areas evaluated include ADLs, IADLs, maintaining health and community engagement. Based on the assessment, the OT may recommend strategies that can be implemented by the home repair specialist to increase home safety and mitigate conditions that pose a risk or barrier to safe, independent daily functioning, such as changes necessary for fall prevention. Using a motivational interviewing approach, the OT engages the participant to develop goals based on difficulties found in the self-report, observations during the assessment, and what the participant identifies is meaningful activity for them in order to preserve their independence and prevent institutionalization. The participant and OT

develop an action plan for addressing these goals. At each visit, the participant reviews their goals, refines them as desired, and practices the action plan with the assessor. Each visit includes training the participant to harness their motivation to work toward their goals.

Complementing the OT work, the RN addresses medical issues that inhibit daily function, such as pain, mood, medication adherence and side effects, strength and balance, and communication with healthcare providers. RN visits focus on goals set by the participant rather than on adherence to medical regimens unless this is the participant's goal.

Each member of the multidisciplinary Goal Engagement Program team focuses on the participant's identified goals to customize the service according to the action plan. Accordingly, this service includes coordination between the OT, RN and home repair specialist to ensure services are targeted to meet the goals identified by the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Goal Engagement Program services include up to 10 in-home visits by the OT or RN. Purchases related to home safety, minor home repairs, and related items and services are limited to $1,800 per participant, per year, when reimbursed on a fee-for-service basis. Participants are limited to one set of Goal Engagement services per calendar year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Goal Engagement Program agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Goal Engagement Program

Provider Category:

Agency

Provider Type:

Goal Engagement Program agencies

Provider Qualifications

License *(specify):*

Occupational Therapy elements of the service must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist.

Skilled nursing elements of the service must be performed by a Registered Nurse or a Licensed Practical Nurse with a valid Massachusetts license.

If the scope of work involves minor home repairs, agencies and individuals employed by the agencies must possess any licenses/ certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc)

Certificate *(specify):*

Staff providing OT and nursing must be CAPABLE certified.
Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

In addition, providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Grocery Shopping and Delivery

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Grocery Shopping and Delivery includes obtaining the grocery order, shopping, delivering the groceries, and assisting with storage as needed.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Grocery Shopping and Delivery Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grocery Shopping and Delivery

Provider Category:
Agency
Provider Type:
Grocery Shopping and Delivery Provider Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home Based Wandering Response Systems

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home Based Wandering Response Systems are communication alert systems for participants at risk for wandering. Participants are outfitted with a device that transmits signals using technology such as GPS or radio frequency. The service includes 24/7 emergency response and location assistance in the event the participant wanders.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Based Wandering Response Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Based Wandering Response Systems

Provider Category:

Agency

Provider Type:
Home Based Wandering Response Provider Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include:
-Maintenance of 24 hour monitoring station, including communication protocols for the hearing-impaired and access to interpreter services in emergencies; and
-Equipment testing.

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 3 years.
For those agencies unable to be monitored via on site visit due to geographical distance, the ASAP will conduct periodic random testing, at a minimum of every 6 months for waiver participants.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request

through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Delivered Meals provide well-balanced meals to clients to maintain optimal nutritional and health status. Each meal must comply with the Executive Office of Elder Affairs' Nutrition Standards, and be religiously and ethnically appropriate to the extent feasible. Home Delivered Meals service includes the preparation, packaging and delivery of meals by trained and supervised staff. More than one meal may be delivered each day provided that proper storage is available in the home. Home delivered meals do not include or comprise a full nutritional regimen.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meal Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Home Delivered Meal Providers
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

Meals must comply with Elder Affairs Nutrition Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivery of Pre-packaged Medication

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home Delivery of Pre-packaged Medication services provide delivery of medications by a pharmacy to a participant's residence. Medication can include, but is not limited to, pre-filled, blister packs, and pre-filled syringes. The cost of the medication is not included in the service.

In addition to providing delivery of medications, the role of the provider includes:
-Reporting to the case management entity any participant concerns, including medication non-adherence
-Reporting to the case management entity within the same business day, when the participant does not answer the door
-Notifying the case management entity the same business day, when the Physician has contacted the pharmacy regarding a change in prescription in order to convey the change in medication and if applicable, request a change in delivery schedule.

This service does not duplicate services available through the State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivery of Pre-packaged Medication

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Pharmacist must meet licensing requirements of the Massachusetts Board of Registration in Pharmacy

Certificate *(specify):*

Other Standard *(specify):*

Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55(Clarification of Client Privacy and Confidentiality Policies). .

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

In addition, providers shall ensure that individuals employed by the agency are able to: perform

assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAP

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home Safety/Independent Evaluations (formerly Occupational Therapy)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home Safety/Independence Evaluations is a periodic, episodic service provided by an Occupational Therapist (OT) to provide in-home evaluations to identify and mitigate home safety risks. The service includes observation and assessment of the participant's normal functioning and completion of day-to-day tasks, including but not limited to ADLs and IADLs, in their living environment. The service also includes recommendations to modify or adapt the participant's approach to such activities and tasks to prevent further injury or disability. The service could also include recommendations to enhance home safety, including recommendations for home repair, modification or assistive devices needed to enable the participant to engage in recommended self-care strategies

Home Safety/Independence Evaluation services must be authorized by the Case Manager in the service plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found at 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services). This service cannot be provided in settings other than the participant's place of residence. The Home Safety/Independence Evaluation service may not be provided at the same time that a participant is enrolled in the Goal Engagement Program waiver service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker/Personal Care agencies
Agency	Health Care Agencies
Agency	Home Health Agencies
Individual	Individual Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independent Evaluations (formerly Occupational Therapy)

Provider Category:

Agency

Provider Type:

Homemaker/Personal Care agencies

Provider Qualifications

License *(specify):*

Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist

Certificate *(specify):*

Other Standard *(specify):*

Education, Training, Supervision:

Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:

Providers must have established strategies to prevent, detect, and correct problems in the quality of

services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independent Evaluations (formerly Occupational Therapy)

Provider Category:
Agency

Provider Type:
Health Care Agencies

Provider Qualifications

License *(specify):*
The agency must be licensed as a Group Practice in accordance with 130 CMR 432.404 (MassHealth Therapist Regulations that describe the provider eligibility requirements for therapy providers) or as a Rehabilitation Center in accordance with 130 CMR 430.600 (MassHealth Rehabilitation Center Regulations that define provider eligibility requirements and program rules).

Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective,

efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independent Evaluations (formerly Occupational Therapy)

Provider Category:
Agency

Provider Type:
Home Health Agencies

Provider Qualifications

License *(specify):*
The agency must be licensed as a Home Health Agency participating in MassHealth under 130 CMR 403.000 (MassHealth Home Health Agency regulations that define provider eligibility requirements and program rules).

Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license or by either a certified occupational therapy assistant or an occupational therapy student under the direct supervision of a licensed Occupational Therapist

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies). .

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Safety/Independent Evaluations (formerly Occupational Therapy)

Provider Category:
Individual

Provider Type:
Individual Occupational Therapist

Provider Qualifications

License *(specify):*
Home Safety/Independence Evaluation services must be performed by an Occupational Therapist with a valid Massachusetts license.

Certificate *(specify):*

Other Standard *(specify):*
Individuals who provide this service shall ensure that they are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Laundry

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Laundry includes pick up, washing, drying, folding, wrapping, and returning of laundry.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Laundry Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Laundry

Provider Category:
Agency

Provider Type:
Laundry Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medication Dispensing System

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Medication Dispensing System is an automated medication dispenser that allows a participant with medication compliance problems to receive pill form medications at appropriate intervals through audible/visual cueing. This system organizes a pre-filled supply of pills and is programmed to deliver the correct dosage of medications when appropriate. The product is lockable and tamper-proof and has a provision for power failure. The cost of the medication is not included in the service.

The Medication Dispensing System shall be authorized only when a responsible formal/informal caregiver can demonstrate the ability to pre-fill medications and monitor the system. The provider must furnish detailed instructions to the caregiver regarding the operation of the system, as well as a signed, written agreement between the provider and the caregiver clearly delineating the responsibilities of each party.

Agencies that provide Medication Dispensing Systems under the waiver are not required to meet the requirements for participation in Medicaid, as provided in 130 CMR 409.00 (MassHealth Durable Medical Equipment regulations that describe the provider eligibility requirements and program rules). This service does not duplicate services available through the State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Equipment Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Dispensing System

Provider Category:
Agency
Provider Type:
Specialized Medical Equipment Provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification

of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy and Client Emergency in the Home Policy.

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Orientation and Mobility Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community and include (a) O&M assessment; (b) training and education provided to participants; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond the home setting to other community settings as well as public transportation systems.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Human Service Agencies
Individual	Certified Orientation and Mobility Specialists (COMS)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Orientation and Mobility Services

Provider Category:
Agency

Provider Type:
Human Service Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individual providers and individuals employed by the agency providing Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals)- certified university program.

Other Standard *(specify):*
Any not-for-profit or proprietary organization that responds satisfactorily to the Waiver provider enrollment process and as such, has successfully demonstrated, at a minimum, the following:
- Providers shall ensure that individual workers employed by the agency have been CORI checked, and are able to perform assigned duties and responsibilities.

Confidentiality: Providers must maintain confidentiality and privacy of consumer information in accordance with applicable laws and policies.

Staff providing services must have:
- Master's degree in special education with a specialty in orientation and mobility; or - bachelor's

degree with a certificate in orientation and mobility from an ACVREP certified university program
Individuals providing services must also have:
- Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment.
- Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Orientation and Mobility Services

Provider Category:
Individual
Provider Type:
Certified Orientation and Mobility Specialists (COMS)
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individual providers of Orientation and Mobility Services must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals) - certified university program.
Other Standard *(specify):*
Individuals providing services must also have:
- Knowledge and experience in the evaluation of the needs of an individual with vision impairment or legal blindness, including functional evaluation of the individual in the individual's customary environment.
- Knowledge and/or experience in educating caregivers or direct care staff, or other individuals who provide services to or are otherwise substantially involved in the major life functions of individuals with vision impairment or legal blindness, in sensitivity to low vision/blindness.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Peer Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Peer Support is designed to provide targeted recovery services to older adults with behavioral health diagnoses. Peer Support assistance includes mentoring participants about self-advocacy and participation in the community, including, but not limited to, such activities as accessing a senior center, getting to medical appointments or a hospital for a medical procedure, assisting with care transitions, and housing paperwork, accompanying for walks to various community locations, and generally engaging to reduce isolation. Peer support may be provided in small groups or peer support may involve one peer providing support to another peer, the waiver participant. Peer support promotes and assists the waiver participant's ability to participate in self-advocacy. The service utilizes trained peers as coaches who have lived experience with mental illness to promote patient-centered care and attainment of measurable personalized recovery goals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not to exceed 16 hours per week.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Peer Support Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Peer Support

Provider Category:
Agency
Provider Type:
Peer Support Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individuals providing Peer Support must have a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training.

Other Standard *(specify):*
Peer Support provider agencies must employ individuals who meet all relevant state and federal licensure or certification requirements in their discipline. If the agency is providing activities where certification is necessary, the agency must demonstrate that individual staff hold such certification. In addition, agencies must demonstrate, at a minimum, the following:
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.
In addition to having a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training, individual staff who provide Peer Support Services must meet requirements for individuals in such roles, including, but not limited to:
- have been CORI checked;
- have experience in providing peer support, self-advocacy, and skills training and independence;
- be capable of handling emergency situations;
- have ability to set limits;
- accept and use supervision;
- have ability to communicate effectively in the language and communication style of the individual for whom they are providing peer supports to;
- have ability to communicate observances verbally and in writing;
- have ability to meet legal requirements in protecting confidential information;
- adapt to a variety of situations;
- respect privacy and confidentiality;
- respect and accept different values, nationalities, races, religions, cultures and standards of living.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.
Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.
Responsiveness:
Providers must be able to initiate services with little or no delay.
Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).
Policies/Procedures:

Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Senior Care Options (SCO)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Waiver participants age 65 and older may choose to voluntarily enroll in a Senior Care Options (SCO) program, a Massachusetts managed care program for dually eligible elders. Waiver participants who choose to enroll in a SCO will receive all waiver services through the SCO.

Senior care organizations authorize, deliver, and coordinate all services currently covered by Medicare and Medicaid, including primary, acute, and specialty care; community and institutional long-term care; behavioral

health; medical transportation; and drugs.

Enrollment in SCO does not substitute for the requirement included in Appendix B-6-a that a participant must receive at least one waiver service per month in order to maintain waiver eligibility.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Senior Care Organization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Senior Care Options (SCO)

Provider Category:
Agency

Provider Type:
Senior Care Organization

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Senior Care Organizations enrolled under contract with MassHealth. A senior care organization is a qualified contractor selected to provide services to MassHealth members aged 65 or older who have chosen to participate in Senior Care Options. Under this program, senior care organizations provide a fully integrated geriatric model of care.

Verification of Provider Qualifications

Entity Responsible for Verification:
MassHealth Office of Long Term Services and Supports

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supportive Day Program

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supportive Day Programs provide support services in a group setting to help participants recover and rehabilitate from an acute illness or injury, or to manage a chronic illness; or for waiver enrollees have an assessed need for increased social integration and/or structured day activities. The services include assessments and care planning, health related services, social services, therapeutic activities, nutrition, and transportation. These services focus on the participant's strengths and abilities while maintaining their connection to the community and helping them to retain their daily skills.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supportive Day Program Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Day Program

Provider Category:
Agency

Provider Type:
Supportive Day Program Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include:
-Procedure for orientation of the participant.
-Maintenance of a confidential record for each participant. Progress notes shall be written as indicated, at least quarterly, and maintained as part of each participant's record.
-Compliance with the state mandatory reporting procedures for reporting suspected cases of abuse or neglect to the adult protective services agency. Staff must be trained in signs and indicators of potential abuse.

Programs must ensure the following:
-An interdisciplinary approach to meeting program goals.
-A variety of services offered to meet the needs of participants.

-A regular daily schedule to provide structure for the participants.
-Sufficient flexibility to accommodate unanticipated needs and events.
-Verbal and non-verbal communication between staff and participants to create a caring environment.

-Sensitivity to various personalities and health conditions to form supportive and therapeutic relationships.
-An adequate number of staff whose qualifications are commensurate with the defined job responsibilities to provide essential program functions.

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs
Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Supportive Home Care Aide

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Supportive Home Care Aides (SHCA) perform personal care and/or homemaking services in accordance with waiver definitions, in addition to providing emotional support, socialization, and escort services to clients with Alzheimer's Disease/Dementia or emotional and/or behavioral problems.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
☐ **Legally Responsible Person**
☑ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies
Agency	Homemaker/Personal Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Home Care Aide

Provider Category:
Agency
Provider Type:
Home Health Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Individuals employed by the agency to provide supportive home care aide services must have the following:
-Certificate of 75-Hour Home Health Aide Training

As well as an additional:
-Certificate of 12 hour Supportive Home Care Aide Training in either Alzheimer's Disease Related Disorders or behavioral health disorders, including substance use disorders.
Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:

Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

All SHCAs must receive an additional 12 hours of initial training from one of the two SHCA training tracks; Alzheimer's Disease and Related Disorders (ADRD) or Mental Health (MH). The following topics are recommended for MH SHCA: limit setting; depression; personality and character disorders; substance abuse; abuse and neglect; and the stigma of mental illness and behavioral disorders. For MH SHCA, the Home Care Aide Council Mental Health Supportive Home Care Aide training curriculum or equivalent is required. The following topics are recommended for ADRD SHCA: understanding Alzheimer's and Dementia; habilitation therapy, communication skills, personal care, behavior as communication and working with families. For ADRD SHCA, the Alzheimer's Association curriculum is required.
An RN shall provide in-home supervision of SHCA's at least once every three months. LPN's may provide in-home supervision if the LPN has a valid license in Massachusetts, and works under the direction of an RN who is engaged in field supervision carried out by the LPN.
In addition, each SHCA receives weekly support through training/in-services, team meetings, or supervision that occurs in-home, by telephone or in person. Team meetings are held at a minimum of two hours quarterly and inclusive of SHCAs, supervisors, and other appropriate personnel involved in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conferences, and to provide support to the SHCA.

In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Home Care Aide

Provider Category:

Agency

Provider Type:
Homemaker/Personal Care Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Individuals employed by the agency to provide supportive home care aide services must have the following:

-Certificate of 75-Hour Home Health Aide Training
As well as an additional:
Certificate of 12 hour Supportive Home Care Aide Training in either Alzheimer's Disease Related Disorders or behavioral health disorders, including substance use disorders.
Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include: Client Not at Home Policy, Client Emergency in the Home Policy; and all policies required by 105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements).

All SHCAs must receive an additional 12 hours of initial training from one of the two SHCA training tracks; Alzheimer's Disease and Related Disorders (ADRD) or Mental Health (MH). The following topics are recommended for MH SHCA: limit setting; depression; personality and character disorders; substance abuse; abuse and neglect; and the stigma of mental illness and behavioral disorders. For MH SHCA, the Home Care Aide Council Mental Health Supportive Home Care Aide training curriculum or equivalent is required. The following topics are recommended for ADRD SHCA: understanding Alzheimer's and Dementia; habilitation therapy, communication skills, personal care, behavior as communication and working with families. For ADRD SHCA, the Alzheimer's Association curriculum is required.
An RN shall provide in-home supervision of SHCA's at least once every three months. LPN's may provide in-home supervision if the LPN has a valid license in Massachusetts, and works under the direction of an RN who is engaged in field supervision carried out by the LPN.
In addition, each SHCA receives weekly support through training/in-services, team meetings, or supervision that occurs in-home, by telephone or in person. Team meetings are held at a minimum of two hours quarterly and inclusive of SHCAs, supervisors, and other appropriate personnel involved

in providing SHCA services. The focus of these meetings is to provide training and group supervision, to conduct case reviews or interdisciplinary case conferences, and to provide support to the SHCA.

In addition, providers shall ensure that individual personal care workers employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 2 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Transitional Assistance

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Transitional Assistance services are non-recurring set-up expenses for individuals who are transitioning from an

institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) assistance with housing search and housing application processes; (b) security deposits that are required to obtain a lease on an apartment or home; (c) assistance arranging for and supporting the details of the move; (d) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (e) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (f) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (g) moving expenses; (h) necessary home accessibility adaptations; and, (i) activities to assess need, arrange for and procure need resources related to personal household expenses, specialized medical equipment, or community services. Transitional Assistance Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Transitional Assistance Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Transitional Assistance services include only those non-recurring set up expenses incurred during the 180 days prior to discharge from a nursing facility or hospital or another provider-operated living arrangement to a community living arrangement or during the period following such a transition during which the participant is establishing his or her living arrangement. Transitional Assistance services comprising home accessibility adaptations must be initiated during the 180 days prior to discharge.

(Only direct expenses for goods and services are reimbursable under this waiver. The case manager works with the participant to develop a list of needs for transition. The case manager coordinates the purchase and delivery of goods and services. This coordination is part of case management, not Transitional Assistance. The ASAP pays individual providers, such as landlords, utility companies, service agencies, furniture stores, and other retail establishments. Thus, "providers" of this service are any of the above, depending on the identified needs of the participant.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency or vendor providing goods and services in accordance with the service description.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Assistance

Provider Category:

Agency

Provider Type:

Any agency or vendor providing goods and services in accordance with the service description.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Will meet applicable State regulations and industry standards for type of goods/services provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

ASAPs

Frequency of Verification:

Every 3 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Transportation Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency

Provider Type:
Transportation Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Education, Training, Supervision:
Providers must ensure effective training of staff members in all aspects of their job duties, including handling emergency situations, and establish procedures for appraising staff performance and for effectively modifying poor performance where it exists.

Adherence to Continuous QI Practices:
Providers must have established strategies to prevent, detect, and correct problems in the quality of services provided and to achieve service plan goals with individual consumers by providing effective, efficient services.

Availability:
Providers must be able to provide contracted service(s) in the geographical areas they designate.

Responsiveness:
Providers must be able to initiate services with little or no delay.

Confidentiality:
Providers must maintain confidentiality and privacy of consumer information in accordance with M.G.L. c.66A (Fair Information Practices Act) and EOEA Program Instruction 97-55 (Clarification of Client Privacy and Confidentiality Policies).

Policies/Procedures:
Providers must have policies and procedures that include:
-Vehicle safety and maintenance
-Assisting passengers on/off vehicles and from door to door
-Ensuring drivers have current licenses as required
-Tracking and scheduling trips

In addition, providers shall ensure that individuals employed by the agency are able to: perform assigned duties and responsibilities; communicate observations verbally and in writing; accept and use supervision; respect privacy and confidentiality; adapt to a variety of situations; and respect and accept different values, nationalities, races, religions, cultures and standards of living.

Verification of Provider Qualifications

Entity Responsible for Verification:
ASAPs

Frequency of Verification:
Every 3 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is provided as an administrative activity by Aging Services Access Points (ASAPs) under contract with the Executive Office of Elder Affairs. SCO participants' Case Management is provided by ASAP Case Management staff under contract with the SCO programs or SCO-employed Case Management staff or Registered Nurses.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal

history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

In accordance with M.G.L. chapter 6, section 172 and 172C (Commonwealth of Massachusetts required Criminal Offender Record Information checks), as well as 101 CMR 15.00 et seq (Executive Office of Health and Human Services required Criminal Offender Record Information checks), the Commonwealth of Massachusetts requires entities to obtain Criminal Offender Record Information (CORI) checks on individuals before they can volunteer, be employed or be referred for employment in an entity providing services to elderly or disabled persons in their homes or in a community setting. CORI checks are statewide in scope. Compliance is verified through on-site audits.

The U.S. Department of Health and Human Services, Office of Inspector General (OIG) may exclude individuals and entities from participation in federal health care programs, including MassHealth, if such individuals and entities have engaged in certain program-related misconduct or have been convicted of certain crimes. Once an individual or entity is excluded by OIG, federal regulations (42 CFR 1001.1901(b)) prohibit MassHealth from paying for any items or services furnished, ordered, or prescribed by the excluded individual or entity.

MassHealth providers have the obligation to screen their employees and contractors, both individuals and entities, to determine if they have been excluded from participation in MassHealth. To comply with this mandate, the State requires that waiver service providers:
1) Develop policies and procedures for regular review of the OIG's List of Excluded Individuals/Entities at both the time of hire and/or contracting and on a monthly basis;
2) Immediately report any discovered exclusion of an employee or contractor to the EOHHS Compliance Office; and
3) Develop reliable, auditable documentation of when these procedures are performed.

Provider compliance with these requirements is monitored as part of the initial enrollment and recredentialing process.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

105 CMR 155.00 (Department of Public Health regulations addressing patient and resident abuse prevention, reporting, investigation and registry requirements) establishes a registry to be maintained by the Massachusetts Department of Public Health which contains: 1) the names of individuals who are certified as nurse aides, and (2) sanctions, findings and adjudicated findings of abuse, neglect, and mistreatment of patients or residents and misappropriation of patient or resident property imposed upon or made against nurse aides, home health aides and homemakers for the abuse, neglect, mistreatment of patients or residents or misappropriation of patient or resident property. ASAPs are required to verify provider agency compliance with 105 CMR 155.000 as part of on-site reviews.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- (●) **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- ( ) **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ( ) **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- (●) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Relatives, but not those who are legal guardians, are permitted to provide waiver services. A relative may not be a legally responsible relative, must be employed by the provider agency, and must meet all qualifications. Under these circumstances, relatives may provide any of the services included in this waiver without limit. Provider agencies are responsible for ensuring that every employee meets service-specific qualifications and must demonstrate compliance with this during on-site audits. All other requirements under this waiver apply, e.g., services must be provided in accordance with an approved plan of care.

- ( ) **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified provider has the opportunity to enroll as a provider of waiver services. Waiver services are coordinated through the network of 26 Aging Services Access Points. In accordance with 651 CMR 14.04(5) (Financial Administrative Responsibilities of ASAPs) procurement of waiver services by ASAPs must be in compliance with Title 45 CFR Part 74, Subpart C, §§ 74.40 through 74.48 and with policies and procedures issued by the Executive Office of Elder Affairs (EOEA).

ASAPs must ensure they have a sufficient number of qualified providers within their geographic service areas that are capable of meeting the needs of Waiver participants through the delivery of timely, accessible, culturally-competent, efficient services. ASAPs must ensure that the provider network is responsive to the linguistic, cultural, and other unique needs of the populations served, including the ability to communicate with participants in languages other than English, and as necessary, with those participants who are deaf, hard of hearing, or deaf blind.

To ensure ASAPs conduct a continuous open enrollment for Frail Elder Waiver service providers, ASAPs must contract with any qualified provider who is willing to accept the terms and conditions of the ASAP.

EOEA requires ASAPs to use specific state standards and due process procedures for soliciting and contracting with providers to deliver waiver services. These standards were established to ensure that waiver services are obtained in an effective manner and in compliance with the provisions of applicable state and Federal statutes, regulations and executive orders, including the federal uniform administrative requirements contained in Title 45 CFR Part 74, subpart C, sections 74.40 through 74.48.

Providers can access information both on the Elder Affairs website and via direct mailings. ASAPs also conduct other outreach methods to reach potential providers, including taking affirmative steps to encourage the participation of small businesses, minority-owned business enterprises and women-owned business enterprises.

Providers interested in enrolling receive a standard package of service information and application documents. Providers of homemaker, personal care and supportive home care aides services may enroll centrally through EOEA while all other service providers enroll directly with the ASAP for the specific geographic area they wish to serve.

The SCOs must comply with the requirements at: 42 CFR 438.214, provider selection requirements for managed care organizations. Any provider contracting with a SCO must have and comply with written protocols including credentialing, re-credentialing, certification, and performance appraisal processes that demonstrate that all members of the Provider Network maintain current knowledge, ability, and expertise in the service or specialty in which they practice.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP a1. All contracted waiver service providers required to maintain licensure/certification, in accordance with waiver/state requirements, adhered to the specifications. Numerator: Number of waiver service providers required to maintain licensure/certification that adhered to these specifications Denominator: Number of audited waiver service providers required to maintain licensure/certification

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe

ASAPs and Senior Care Organizations (SCO)		Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP b1. Non-licensed/non-certified waiver service providers adhered to provider qualification specifications, in accordance with state requirements. Numerator: Number of non-licensed/non-certified waiver service providers that demonstrated compliance with qualification requirements Denominator: Number of non-licensed/non-certified waiver service providers audited

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

	Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP c1. Waiver service providers participated in trainings, in accordance with state requirements. Numerator: Number of waiver service providers that produced documentation of required trainings Denominator: Number of waiver service providers audited

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The setting in which each waiver participant resides and the predominant settings wherein the services provided through this waiver are delivered are in the participant's private residence within the community.

The Massachusetts Executive Office of Health and Human Services (EOHHS), the single State Medicaid Agency, convened an interagency workgroup to address how best to comply with the requirements of the federal Home and Community Based (HCB) settings requirements at 42 CFR 441.301 (c)(4)-(5). The Executive Office of Elder Affairs (EOEA), an agency within EOHHS that has primary responsibility for day-to-day operation of the Frail Elder Waiver, was a member of the workgroup. EOEA undertook a review of all their regulations, standards, policies, service descriptions, and other provider requirements to ensure compliance of settings with the new federal requirements, as they apply within this waiver. The Frail Elder Waiver supports individuals who reside in their own homes or apartments, in homes and apartments with family members and other informal supports, or in a home or apartment of a caregiver with up to one additional waiver participant. These settings fully comply with the HCBS Regulations. Although this waiver does not provide residential services, Frail Elder Waiver Participants may receive the following waiver services outside their home: Supportive Day Program. Frail Elder Waiver participants may also reside in Congregate housing and receive their waiver services within this residential setting. As defined in Massachusetts, Congregate housing is a shared living environment designed to integrate housing and certain services needed by elders and younger disabled individuals who choose this environment as their home. Congregate housing is not a waiver service, nor is it a 24/7 staffed residence. Services are not inherent to the congregate setting, nor are residents required to receive services in order to reside in congregate housing.

EOEA's review and assessment process for these residential and non-residential settings included: a thorough review of regulations, policies and procedures; waiver service definitions; provider qualifications and quality management and

oversight systems to determine whether the systemic infrastructure was consistent with the principles of community integration; development of an assessment tool based on the exploratory questions that CMS published; and review of the existing non-residential settings to determine if these settings meet standards consistent with the HCB settings requirement. As detailed in the Site-Specific Assessment and findings sections and summarized in Table 2 of the STP submitted to CMS in September 2016, fifty five out of fifty six Supportive Day Program providers available to Frail Elder Waiver Participants have been determined by EOEA to comply fully with the Community Rule. The Supportive Day Program found to be not compliant does not serve waiver participants and will be precluded from providing services to waiver participants in the future. 43 out of 44 Congregate Housing sites were found to be HCB setting compliant from the onset. One Congregate setting required minor modifications to become compliant. EOEA verified that this setting completed necessary program changes and physical alterations for continued compliance.
The systematic and site-specific oversight is completed ongoing by EOEA agents (the ASAPs). The ASAP reviews any new setting as necessary to ensure full compliance as required by EOEA.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Comprehensive Service Plan (CSP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

  Case Managers have a Bachelor's degree in social work, human services, nursing, psychology, sociology or a related field. Candidates with a Bachelor's degree in another discipline shall demonstrate experience or strong interest in the field of human services via previous employment, internships, volunteer activities and/or additional academic studies. Aging Services Access Points may request a waiver of the Bachelor's degree requirement from the Executive Office of Elder Affairs for candidates who offer special skills and/or backgrounds, such as those with bilingual ability and bicultural status.
- [ ] **Social Worker**

  Specify qualifications:
- [ ] **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ( ) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- (•) **Entities and/or individuals that have responsibility for service plan development may provide other direct**

waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

651 CMR 14.00 (Department of Elder Affairs regulations for Aging Services Access Points that describe the functions and responsibilities of ASAPs) prohibits Aging Services Access Points from providing waiver services, except for nutrition services. In regions where the local Aging Service Access Point is also a provider of Title III meals (usually the Area Agency on Aging or AAA), home delivered meals may be provided by the ASAP. Administrative separation between ASAP and AAA functions ensures that the service plan development process focuses on documented participant needs. In no circumstances are the same individuals responsible for service plan development and the direct provision of waiver services. Through the Interdisciplinary Case Management assessment process, participant needs are identified, the options for waiver and non-waiver services are discussed with the participant, and a service plan is developed. Each service plan is inclusive of participants' values, goals and preferences. Services are provided solely on the basis of assessed needs documented in the Comprehensive Data Set (CDS) assessment and the service plan. The State reviews a sample of service plans to ensure that all needs identified have been addressed through either waiver or non-waiver services.

In addition, 651 CMR 14.00 permits the Secretary of Elder Affairs to grant a waiver and approve an ASAP's request to provide a service on the basis of public necessity and convenience. The waiver request must identify the conditions that make a waiver necessary, what steps have been taken to resolve current issues and ensure future waivers will not be necessary; the consequences to the participants of the ASAP of not granting the waiver request; and the consequences to the ASAP of not granting the waiver request.

A Senior Care Organization does not provide direct waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service plan (Comprehensive Service Plan (CSP)) development process for all waiver participants (including SCO-enrolled participants) is driven by the waiver participant and facilitated by Case Managers or Registered Nurses utilizing a person-centered planning approach and assessment tool designed to promote the participant to live as independently and self-sufficiently as possible and as desired. EOEA has implemented a person-centered approach for all waiver participants. This approach is designed to put the participant at the center of the service planning process in the development of and in changes to his/her CSP. The process is designed to maximize participants' choice and control, including selection of waiver and non-waiver services appropriate to meet their needs and the manner in which such services are implemented.

The Case Manager or Registered Nurse meets with the participant or authorized representative prior to any Comprehensive Service Plan meeting to ensure the participant has the information he/she needs to exercise choice and control in the service planning process. This discussion includes:
• An explanation of the service planning process to the participant/representative.
• Identification of the participant's goals, strengths, and preferences regarding services and Interdisciplinary Case Management Team members (i.e., who participates in the CSP development process).
• A review of all assessment materials and the participant's identified needs.
• A review of waiver services, State Plan and other services available to the participant and how they relate to and will support the participant's needs and goals.

In all CSP development or changes, Case Managers or Registered Nurses work with the Interdisciplinary Case Management team, which is comprised of the waiver participant, family members, and others identified by the participant. Some examples of who may be included as parts of the Interdisciplinary Case Management Team are: representatives from the waiver service provider, the ASAP or SCO registered nurse, and ASAP or SCO supervisory staff. EOEA requires that the Interdisciplinary Case Management team is centered around the participant and involves or consults with appropriate family members, referral sources, physicians, home health agencies, and

other persons and organizations identified by the waiver participant. Any persons or organizations that the waiver participant wishes to exclude from the service plan development process are documented at the initial home visit and subsequently as needed or desired by the waiver participant. The participant may choose to identify other people, for example a family member, to be present for the assessment visit and to participate in comprehensive service plan development.

The CSP development process is conducted utilizing a person-centered planning approach designed to promote the independent functioning of the participant in the least restrictive environment and to ensure that services are provided in a manner acceptable to the participant. Case Managers must be aware of and know how to access a wide variety of community-based services in order to explain to participants the full array of waiver and non-waiver services available to meet the participant's needs.

The Interdisciplinary Case Management approach is designed to incorporate principles of person-centered planning, including emphasizing the need for information and training to allow for informed decision-making. Additional focus is placed on maximizing participant opportunities for control, including in the selection of services most appropriate to meet the participant's needs and the manner in which the CSP is implemented. The training emphasizes that all participants, regardless of disability, are capable of directing their own care, although the extent to which they do so will depend on each participant's preferences and ability.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For all waiver participants, Case Managers and Registered Nurses follow standard procedures and time frames in performing the intake, assessment, case conferencing, service planning, and review process that ensure participants' strengths, needs, risk factors, personal goals and preferences are identified and appropriately addressed in the Comprehensive Service Plan (CSP).

Waiver participants' needs are identified throughout the referral, needs assessment, and the person-centered planning processes that lead to development of the CSP. Through the person-centered planning process and using a state-approved tool, the needs assessment gathers information on a participant's goals, strengths, clinical needs, support/service needs and need for training to enhance community integration and increase independence, including the opportunity to seek employment, engage in community life and control personal resources. The service needs assessment reflects the functioning of the participant in their current setting. Participants may be assessed in institutional settings in anticipation of returning to the community. The process also identifies informal supports available to the participant and all other resources that may be available to assist the participant in remaining in the community, achieving positive outcomes and avoiding unnecessary utilization of waiver services.

The CSP development processes utilized in this waiver follow EOEA-mandated procedures in performing the intake/ assessment, ongoing assessment, case conferencing, service planning and supervisory review that ensure all participants' needs, risk factors and personal goals are identified and appropriately addressed.

The initial assessment for eligibility and development of the Comprehensive Service Plan (CSP) is conducted by a Case Manager or an ASAP RN. Assessments are documented on the Comprehensive Data Set (CDS), a uniform tool that includes demographic, ADL/IADL, social, emotional, cognitive, medical, environmental and nutrition information. The CDS contains, in its entirety, the MDS-HC. This information, as well as data regarding areas in which assistance is provided by existing formal and informal supports, and information about the individual's strengths, preferences and goals, informs the development of the Comprehensive Service Plan (CSP). The Case

Manager or RN explains programs and services to the participant and assists him or her with clarifying his or her goals in order to support the participant in selecting an array of appropriate services and providers through which to receive preferred/needed services, while working toward goals and maintaining long term independence in the community.

Linked to the participant's vision, goals and needs, the Case Manager or Registered Nurse facilitates development of the CSP with the participant and engages the Interdisciplinary Case Management Team as the participant desires. The participant's representative, if applicable, and other formal and informal supports identified by the participant make up the Interdisciplinary Case Management Team and are part of the service planning process. This may include providers with knowledge and history of serving the participant. The Case Manager or Registered Nurse is responsible for providing information about non-waiver services and supports to address identified needs, coordinating and communicating Comprehensive Service Plans and/or changes to appropriate community agencies and ensuring that waiver participants have access, as appropriate, to waiver and Medicaid State Plan services. The Case Manager or Registered Nurse also identifies other public benefits to ensure that waiver participant needs are met.

The Case Manager or Registered Nurse's responsibilities include: facilitating the service planning process and development of the CSP with the participant and his/her representative, ensuring the final plan addresses the participant's expressed and assessed needs and is approved by the participant, monitoring the participant's satisfaction with the plan and assisting to ensure that the participant receives the services in the plan. In addition, the Case Manager or Registered Nurse is responsible for facilitating subsequent monitoring meetings, meeting routinely with the participant to assess the CSP's success in supporting the participant's identified goals and making changes to the CSP with the participant as necessary or as requested by the participant. The Case Manager or Registered Nurse is also responsible for coordinating and communicating Comprehensive Service Plans/changes to the involved providers and appropriate community agencies to ensure that waiver participants have access, as eligible, to other public benefits/entitlements and other community services.

In instances when the participant is at a high risk and lacks adequate supports, the Case Manager or Registered Nurse is responsible for ensuring that a 24-hour back up plan is created for use in the event that waiver services become unavailable, and that the participant understands and is able to implement the 24-hour back up plan when necessary.

The participant/representative may choose to identify other people or other members of the Interdisciplinary Case Management Team, for example a representative such as a family member or friend, to be present for the assessment visit and subsequent service planning meetings. The waiver participant/representative may also choose to exclude individuals from the Comprehensive Service Plan development process.

The CSP will be written in plain language and in a manner accessible to the participant. If the primary language of the program participant, or his/her representative, is not English, the information in service plans must be translated into his/her primary language and/or explained with the assistance of an interpreter. If the participant is unable to read or exhibits cognitive deficits (e.g. memory disorder) that may compromise his/her understanding of the service plan, and he or she does not have a representative, the case manager shall ensure that the information is cognitively accessible.

Participants will receive a scheduled visit either by the RN or Case Manager at least every six months or more frequently, as needed, to respond to changes in the participant's health condition, formal or informal supports or other changes. Visits are scheduled at times convenient for the participant /representative and include any persons the participant/representative wishes to be present. In addition, the Case Manager maintains regular telephone contact with the participant/representative between visits. The CSP may be revised at any point by the Case Manager with the approval of the participant/representative, based on changes in the participant's needs or circumstances, effectiveness, or at the participant's request.

Reassessments of the waiver participant are documented through the CDS/MDS-HC or a comparable assessment tool. For all participants, the Case Manager or RN who completes the visit with the participant enters case notes that document each reassessment in the participant's record. Case notes are also used to document all contact with the participant, family, vendors and any other persons involved with the participant. Adjustments to the service plan are made in consultation with the participant, service providers and informal supports to ensure that the service plan continues to promote the independent functioning of the participant in the community and that the services continue to be provided in a manner acceptable to the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The evaluation and management of risk is an integral component of interdisciplinary care management provided to all participants in the Frail Elder Waiver.

Risk assessment and mitigation are a core part of the service planning process. Through multiple assessments that are specific to the participant and reviewed during the comprehensive service planning process, potential risks to the participant's health and safety and the participant's ability to remain in the community are identified by the participant with the case manager or Registered Nurse's assistance. With the participant, the case manager or Registered Nurse leads the Interdisciplinary Case Management Team in the development of prevention and response strategies that will mitigate these risks. Having the participant at the center of this process ensures that the responses are sensitive to his or her needs and preferences.

During the initial comprehensive assessment, and the development of the Comprehensive Service Plan (CSP), potential risks to the participant's health and safety and the participant's ability to remain in their community setting are identified. Areas of potential risk are discussed with the participant and the Interdisciplinary Case Management team to identify services or interventions to mitigate those risks. Risk factors reviewed include, but are not limited to, health risks and/or daily care needs, behavioral risks, and risks to personal safety.

When a participant is determined to be high risk as identified by the risk assessment process, the Case Manager or RN works with the participant and/or representative to create a back-up plan to mitigate the identified risks. The Case Manager or RN documents the specific risks the Interdisciplinary Case Management team has identified, along with preventive measures or supports that would minimize these identified risks. At each reassessment visit, the participant together with the case manager and other Interdisciplinary Case Management team members, family members, or other identified individuals, as appropriate, will review any identified risks as well as any incidents associated with the participant's identified risk factors, and steps to further minimize these risks, and will revise the plan as appropriate based on updated information. Once the back-up plan is created and included in the participant's record, Waiver service providers have the primary responsibility for ensuring coverage of the participant's service plan and communicating when services cannot be provided as scheduled.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

As part of the comprehensive service planning process case management staff review with participants the range of waiver and non-waiver services available to address the participant's identified needs and preferred services. The Interdisciplinary Case Management team works with the participant to identify any specific preferences or requirements, such as a need or preference for a worker who speaks a particular language. The case manager makes inquiries regarding the availability of workers, discusses options with the participant (including schedules), and works with the participant to identify the provider agency best able to meet the requirements and preferences of the waiver participant. The participant contacts his/her case manager or other members of the Interdisciplinary Case Management team to report any dissatisfaction with the service providers. At each visit the case manager inquires as to the participant's satisfaction with both the service plan and the service providers. The participant may request a change in workers or vendor agencies as desired.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The CDS/MDS-HC is completed for all waiver participants to support the waiver service plan. The identified needs of the participant are outlined in a Comprehensive Service Plan (CSP). Records are reviewed by ASAP and SCO supervisory staff to assure that the assessed needs including the applicable safeguards and standards of care are met by either waiver services or through other means. In addition, EOEA reviews a statistically significant sample of waiver records to ensure assessed needs are being met as well as that any health and welfare concerns are being addressed. The Office of Long Term Services and Supports reviews a sample of SCO waiver participants' records to ensure assessed needs are met and health and welfare concerns are addressed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Electronic service plan records are recorded by ASAP staff and maintained in the Senior Information Management System (SIMS). Written copies of the Comprehensive Service Plan are maintained in the participant's record by the ASAP in accordance with 651 CMR 14.030 and Elder Affairs Documentation Standards. Similarly, SCOs maintain electronic and paper records on all waiver participants. All records are maintained for seven years after the date the case is closed.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Case Manager with the support of other members of the Interdisciplinary Case Management team has overall responsibility for monitoring the implementation of the Comprehensive Service Plan (CSP) to ensure that the participant is satisfied with waiver services and that services are furnished in accordance with the CSP, meet the participant's needs and achieve their intended outcomes. This is done through scheduled reassessments and ongoing contact with the participant, his/her representatives and members of the Interdisciplinary Case Management team.

The participant receives, at a minimum, an in-person visit by either an ASAP or SCO case manager or RN every 6 months. The case manager or RN may determine that additional visits would be necessary in response to changes in

the participant's health condition, formal or informal supports or other changes. Visits are scheduled at times convenient for the participant and include any persons the participant wishes to be present. In addition, the case manager maintains regular contact with the participant through a variety of means and in the ways the participant prefers between the in-person visits. The CSP may be revised at any point by the case manager at the direction of the participant, based on changes in the participant's goals, needs or circumstances.

The case manager or RN reviews with the participant the range of waiver and non-waiver services available to address the participant's identified needs, the providers of such services and ensure access to services. At each in-person visit and telephone contact, the case manager inquires as to the participant's satisfaction with both the services included in their CSP and the service providers. The participant has free choice of service providers and may, at any time, request a change of service providers.

Case managers or RN monitor services to ensure they are delivered in accordance with the service plan and that they are meeting the participant's needs and preferences. If problems are identified they are promptly addressed with the provider.

EOEA promotes person-centered empowerment and supporting personal choice as a core value and strives for comprehensive service planning that is responsive to participant needs. Service planning involves the ongoing process of identification, assessment and mitigation of risk. Participants are informed of the identified or potential risks and are supported by their Interdisciplinary Case Management Team around their goals and preferences in the identification of community supports and strategies to minimize these risks while ensuring maximum opportunities for independence.

For high-risk participants the case manager reviews the identified risks and back-up plan and updates, as needed, as a component of the participant's service planning process. The case manager ensures that the participant, and his or her representative/informal supports as appropriate, understand and are able to implement the back-up plan when necessary. Case managers work with the participant's service providers to ensure that the identified risks are appropriately managed.

There are several additional quality management processes that assure that individual participants are getting the services they need and that their health and welfare is protected. These processes are described more fully in other appendices, and include but are not limited to:

a) Assessment of Health & Welfare concerns such as abuse, neglect, poor hygiene, environmental safety, falls risk, and medication management needs at least every 6 months
b) incident reporting and management (described in Appendix G)
c) investigations process (described in Appendix G)
d) risk assessment and management system
e) periodic progress and update meetings
f) ongoing contact with the participant and service providers.

By contract, waiver service providers must report all incidents and changes in the participant's condition or health and welfare concerns to the Case Manager or GSSC immediately. Any incident that is considered to be a Critical Incident is reported to EOEA and LTSS for SCO enrolled participants. A critical incident that must be shared with EOEA and LTSS may include: death, exposure to hazardous materials, medication errors, natural disasters, communicable diseases, physical injury, suspected criminal activity, neglect, missing persons, or significant property damage. EOEA and LTSS track incidents ensuring appropriate follow up to any reported incident, as well as trends with providers and/or particular home care aides. The ASAP or SCO ensures proper reporting of all incidents as part of ongoing provider monitoring and agency oversight which may result in investigation and corrective action as needed. ASAPs and SCOs share any corrective action plans with EOEA to ensure action is complete and thorough.

Individuals and families are provided with information on whom to contact in an emergency and how to access emergency services as needed.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

651 CMR 14.00 (Executive Office of Elder Affairs regulations for Aging Services Access Points that describe the functions and responsibilities of ASAPs) prohibits Aging Services Access Points from providing waiver services, except for nutrition services. In regions where the local Aging Services Access Point is also a provider of Title III meals (usually the Area Agency on Aging), home delivered meals may be provided by the ASAP. Administrative separation between ASAP and AAA functions ensures that the service plan development process focuses on documented participant needs. In no circumstances are the same individuals responsible for service plan development and the direct provision of waiver services. Through the Interdisciplinary Case Management review process, changes in a participant's needs are identified, the options for waiver and non-waiver services are discussed with the participant, provider options are discussed, and the service plan is implemented, monitored, reviewed, and updated as needed. To ensure participants' service plans have all needs identified and addressed through either waiver or non-waiver services, the State reviews a statistically significant sample of participant records.

SCOs do not provide direct waiver services to their enrollees.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP a1. The required assessment tool was completed for all waiver participants.
Numerator: Number of waiver participants with a completed assessment on the required tool Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
SCO quality report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Senior Care Organizations (SCO)	☑ **Annually**	☑ **Stratified** Describe Group: By SCO: 95% confidence

		interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP a2. The service plans addressed assessed needs through waiver or non-waiver services. Numerator: Number of waiver participants with service plans addressing assessed needs Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA review of data in SIMS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative**

		Sample Confidence Interval = 95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Senior Care Organizations (SCO)	☑ **Annually**	☑ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SPa3. The service plans addressed personal goals through waiver services or through other means. Numerator: Number of consumers whose person-centered goals are addressed during service plan development Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA review of data in SIMS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval =

		95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Senior Care Organizations (SCOs)	☑ **Annually**	☑ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP c1. Case Managers documented their review of waiver participants' service plans within the past year. Numerator: Number of waiver participants with a documented review/update of their service plan within the past year Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Senior Care Organizations (SCOs)	☑ **Annually**	☑ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP d1. Services were delivered according to the type, scope, amount, duration, and frequency identified in the service plan. Numerator: Number of service units delivered for all waiver participants Denominator: Number of service units authorized in the service plan for all waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service plan data and service delivery data from SIMS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: SCOs	☑ **Annually**	☑ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
SP e1. Waiver participants were afforded choice when offered services/providers.
Numerator: Number of waiver participants who were afforded choice when offered waiver services/providers Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
EOEA review of data in SIMS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence interval, +/-5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:

SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Senior Care Organizations (SCO)	☑ **Annually**	☑ **Stratified** Describe Group: By SCO: 95% confidence interval, +/-5% margin of error
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Individuals are afforded the opportunity to request a fair hearing in all instances when they: (a) are not provided the choice of home and community-based services as an alternative to institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; and/or, (c) their services are denied, suspended, reduced or terminated.

Individuals are informed in writing of the procedures for requesting a Fair Hearing as part of the waiver entrance process by letter. If entrance to the waiver is denied, the person is given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver. In order to ensure that individuals are fully informed of their right to Fair Hearing, the written information will be supplemented with a verbal explanation of the Right to Fair Hearing when necessary. Appellants are notified that they can seek judicial review of the final decision of the hearing officer in accordance with M.G.L. c. 30A (the Massachusetts Administrative Procedures Act). It is up to the individual to decide whether to request a Fair Hearing.

Whenever an action is taken that adversely affects a waiver participant after enrollment (e.g., services are denied, reduced or terminated), the participant is notified in writing by letter ("Notice") on a timely basis in advance of the date of implementation of the action. The Notice includes information about how the participant may seek Review of the adverse action before an Internal Case Review Committee. The Notice informs the participant that services will be continued, as appropriate, at their present level during the appeals process. A participant who disagrees with the Review decision of the Internal Case Review Committee may request an Appeal of the Committee's decision to a Hearing Officer and is informed in writing of that right upon receipt of the Review decision. A participant who disagrees with the Appeal decision of the

Hearing Officer can seek further review of the Appeal decision with the Division of Administrative Law Appeals and is informed in writing of that right upon receipt of the Hearing Officer's Appeal decision. Individuals are notified that decisions of the Division of Administrative Law Appeals are reviewable in the Superior Court. It is up to the participant to decide whether to request a Fair Hearing.

All notices regarding the right to review or appeal provide a description of the review and appeals processes and instructions regarding how to initiate those processes. The notices describe the procedures for requesting and receiving a fair hearing for any decision adverse to the individual.

All reviews and appeals are conducted in accordance with Massachusetts Administrative Procedures Act (M.G.L. c. 30A) and the Executive Office of Administration and Finance Standard Adjudicatory Rules of Practice and Procedure (801 CMR 1.00 et seq.).

Written copies of notices of adverse actions and the notices regarding Fair Hearings are maintained in the participant's paper record kept by the ASAP.

In addition, pursuant to federal regulation 42 CFR 438 and SCO contract requirements, each SCO offers a grievance and appeal system to all of its enrollees, including waiver participants. After exhausting the internal appeal process, a participant may request a Fair Hearing in accordance with the process for Fair Hearings described above, and pursuant to the Senior Care Options Contract and 42 CFR 438.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the

mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Executive Office of Elder Affairs defines and establishes requirements for reporting critical incidents in the EOEA "Critical Incident Reporting Form" and in accompanying instructions, "Critical Incident Report Form: Instructions," that EOEA issues to the ASAPs. The Critical Incident Report Form and Critical Incident Report Form: Instructions define critical incidents as sudden or progressive events that require immediate attention and action to prevent/minimize a negative impact on the health and welfare of a waiver participant served by an ASAP or SCO. Critical incidents may include, but are not limited to: death of a participant due to unnatural causes, exposure to hazardous material, medication error, unauthorized restraints, natural disaster, serious physical injuries, criminal activity impacting the participant, serious neglect, missing persons, and significant property damage.

ASAP, SCO, and Waiver service provider staff are required to report any event of concern, unanticipated changes in the participant, or critical incidents to their respective agencies immediately. Each ASAP/SCO receives and responds to critical incidents directly. All critical incidents involving waiver participants are communicated to EOEA and the MassHealth Office of Long Term Services and Supports by phone on the day the ASAP/SCO staff learns of the incident or through secure email on the prescribed Critical Incident Report Form within two business days. EOEA reviews the information reported to ensure that the appropriate response to the critical incident has occurred to ensure participant safety. EOEA logs incidents and tracks for trends related to agencies or providers. EOEA communicates any agency, provider, or systemic trends to the ASAPs, and specifies action steps to address the identified issue(s), through regular meetings and ongoing communication with the ASAPs. The MassHealth Office of Long Term Services and Supports SCO unit communicates with SCO programs to address health and welfare concerns identified through critical incident tracking for waiver participants receiving SCO services. Through regular communication and meetings with the ASAPs and SCOs, respectively, EOEA and the MassHealth Office of Long Term Services and Supports identify needed changes in policy and/or programming based on critical incidents trends and address concerns raised by ASAPs and SCO regarding barriers they encounter specific to securing elders' health and well-being.

Additionally, a secondary level of reporting is required for critical incidents involving abuse, neglect, or exploitation. These include incidents of physical abuse, sexual abuse, emotional abuse, self-neglect, caregiver neglect, and financial exploitation. All ASAP/SCO case managers and RN's are Mandated Reporters and are required to report incidents of abuse, neglect and financial exploitation to protective services.

The Executive Office of Elder Affairs administers a statewide system for receiving and investigating reports of elder abuse and neglect, and for providing needed protective services to abused and neglected elders when warranted in accordance with M.G.L. Chapter 19A, Section 14 et seq. In furtherance of this responsibility, EOEA has established 20 designated Protective Service (PS) agencies throughout the Commonwealth to respond to reports of elder abuse. The goal of Protective Services is to remedy or alleviate the abusive situation and to prevent the reoccurrence of abuse.

Chapter 19A of the Massachusetts General Laws contains provisions governing the "Elder Protective Services" (PS) program. Section 14 of Chapter 19A defines abuse as "an act or omission which results in serious physical or emotional injury to an elderly person; or financial exploitation of an elderly person; or the failure, inability or resistance of an elderly person to provide for him or herself". The scope of the PS program includes the investigation of all cases of abuse where the alleged abuser is a family member; an informal or unpaid caretaker; has a fiduciary relationship or a voluntary relationship with the elder. Cases are screened for appropriate intervention and follow-up. These cases include: physical abuse, sexual abuse, emotional abuse, threats, intimidation, financial exploitation, neglect and self-neglect. In making decisions about the presence of physical, sexual and emotional abuse, caretaker neglect, financial exploitation and self-neglect, PS workers and their supervisors make reasoned and careful decisions about each elder's situation. Therefore, it is essential for investigations to be conducted and documented in accordance with the requirements.

EOEA operates a 24 hour a day, 7 days a week Central Intake Unit's Elder Abuse Hotline to allow for reports to be made at any time. The Hotline provides a telephone number for calling as well as a web-based reporting format through the Commonwealth of Massachusetts' website.

Each of the 20 Protective Service Units across the state have the capacity to receive and respond to Emergency and rapid response reports of abuse on a 24 hour per day, seven day per week basis. Each report is screened by a Protective Services Supervisor to determine whether the allegation constitutes a Reportable Condition to Protective Services and to determine if an Emergency, Rapid Response or Routine response is needed.

For all reports screened in as "Emergency" an assessment of the allegedly abused elder must occur within 24 hours of the report. For reports screened in as rapid response, an assessment of the allegedly abused elder must occur within 72 hours. For other non-emergency reports, an assessment of the allegedly abused elder must occur within 5 days of the report.

In accordance with 651 CMR 5.19: Reporting to District Attorneys, if an elder has died as a result of abuse, the death shall be immediately reported to the District Attorney of the County in which the abuse occurred.

In accordance with 105 CMR 155.00: PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY, the Massachusetts Department of Public Health (DPH) is responsible for investigating all reports of patient abuse, neglect and financial exploitation by paid caregivers such as home health aides and homemakers. DPH also must maintain a registry which contains any findings which conclude that the individual about whom the complaint was registered, did, in fact, commit the acts. The programs operated by the Department of Public Health and EOEA protect the health and welfare of all residents aged 60 and over, including waiver participants.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Waiver participants receive a packet of information from the ASAP when they are first enrolled for services with the ASAP. It is the responsibility of the ASAP case manager/RN to give the packet of information to and verbally review the packet with the participant, and document that the information was reviewed, received, and verbally reinforced with the participant. The packet includes a brochure developed by the Executive Office of Elder Affairs Protective Services Unit entitled "Help Prevent Elder Abuse, Neglect, Financial Exploitation and Self-Neglect." The brochure is available in 11 languages. The brochure describes what elder abuse is; who is protected; who must report it; how to report it and what happens after a report is made. The materials are customized for each ASAP to specify which of the 20 local Protective Services Agencies covers the ASAP's service area, and provides the Protective Services Agency's contact information as well as the state's 24 hour/ 7 day a week Critical Intake Unit's Elder Abuse Hotline telephone number. Also included in this packet is how the participant can contact the agency and case manager to let them know

if he or she has a concern related to abuse, neglect or financial exploitation.

Similarly, waiver participants enrolled in a SCO receive written information about abuse neglect and exploitation, including how to report such abuse. SCO case managers are responsible for verbally reviewing this information with the participant, and documenting that the information was reviewed, received, and verbally reinforced with the participant. The information provided includes the brochure described above as well as information about how participant can contact the SCO and their case manager to let them know if he or she has a concern related to abuse, neglect or financial exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

ASAP/SCO have established procedures with ASAP/SCO staff and waiver service providers to ensure incidents effecting the health and welfare of any waiver participant are identified, assessed and triaged and that remediation occurs. ASAP/SCO staff are trained to identify, gather and report critical incidents to supervisors and management personnel. Additional methods for receiving critical incident report information include Participant Grievance Process,-Participant Satisfaction Surveys,-Vendor Comment Log (from participants and ASAP Staff).

Waiver service providers are required to report to the ASAP or SCO on same business day any hospitalization, addition or loss of household member, unexplained absences from home, alleged theft, alleged breakage of participant's possessions, injury to employee or participant, participant employee complaint, change in participant's status regarding cognitive, physical, or behavioral functioning. ASAP/SCO review and evaluate Waiver service provider reports within 24 hours to determine remediation of event and escalation to EOEA per critical incident report procedure.

Waiver service provider agencies are required to report to the ASAP/SCO immediately (day or night) for physical abuse, sexual abuse, emotional abuse, self-neglect, caregiver neglect, and financial exploitation in accordance with 105 CMR 155.00: PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY (the state's mandated reporter regulation). Protective Service reports are then screened and investigated per state regulation as described below.

In accordance with 651 CMR 5.00: ELDER ABUSE REPORTING AND PROTECTIVE SERVICES PROGRAM, (651 CMR 5.10 Investigation) the applicable Protective Service Agency completes an investigation, generally comprised of one or more visits to the residence of the elder, designed to assess the allegations of abuse reported; evaluate the condition of the elder including the decisional capacity and functional capacity of the elder to determine if there is reasonable cause to believe that the elder is suffering from abuse; and establish a basis for offering services if the existence of abuse is confirmed. The regulation (651 CMR 5.10(2) Process) establishes timelines for completing the investigation as follows: for all reports screened in as "Emergency," an assessment of the allegedly abused elder must occur within 24 hours of the report; for reports screened in as rapid response, an assessment of the allegedly abused elder must occur within 72 hours; for other non-emergency reports, an assessment of the allegedly abused elder must occur within 5 days of the report. All investigations must be completed within 30 days.

The Protective Services regulation provides that Mandated Reporters are notified in writing of the action taken in response to the report within 45 calendar days of the report; other reporters are notified upon request. 651 CMR 5.08 (2)(e)(3)

EOEA is informed of any critical incident reports of a serious nature. These reports are made directly to the Director of Home and Community Programs or the Chief of Staff as well as documented in writing. SCO programs report all critical incidents involving waiver participants to the LTSS as required for all MassHealth programs.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Within EOHHS, EOEA is responsible for the oversight of the reporting of and response to critical incidents or events that affect all waiver participants. Critical incidents are addressed and reported as they occur by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. As noted in Appendix A Section 2, staff within EOHHS, from MassHealth and EOEA, meet at least monthly and on an ad hoc basis whenever necessary.

Every critical incident report submitted is reviewed and must include steps taken to mitigate risk, and prevent future incidents. If any required information is not included in the report, EOEA or LTSS request the necessary information from the ASAP or SCO to ensure proper follow up is completed. This follow up may include: reassignment of provider, corrective action required by provider, or a formal plan to ensure the participant's safety. Incidents involving fatalities of a suspicious nature, imminent risk, employee misconduct and those with media involvement are also shared with EOHHS leadership.

MassHealth's LTSS is the state entity responsible for the oversight of the reporting of and response to critical incidents or events that affect waiver participants enrolled in SCO. Any critical incident which falls under Protective Services is investigated by the PS unit according to state regulations (651 CMR 5.00), and is maintained by this unit in regards to oversight of the case after the report is substantiated. Any critical incident received by LTSS or the PS unit is shared with EOEA and tracked to ensure proper follow up on each waiver participant.

The Massachusetts Department of Public Health is the other state agency responsible for the oversight of the reporting and response to all reports of abuse, neglect and financial exploitation of any waiver participants by paid caregivers, such as home health aides and homemakers. Oversight is done on a case-by-case basis and substantiated findings are maintained in a DPH registry.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

(●) **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Within EOHHS, EOEA and DPH receive reports of the unauthorized use of restraints or seclusion through protective service reports or provider complaints. In accordance with 105 CMR 155 et seq (Department of Public Health Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program) all reports of abuse, neglect and mistreatment, including restraining or secluding an elder, require investigation. As noted in Appendix G-1-e, critical incidents are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to MassHealth. Additionally, EOEA reports and monitors consumer assessment data for any indications of unauthorized use of restraints.

( ) **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Within EOHHS, EOEA and DPH receive reports of the unauthorized use of restrictive interventions through protective service reports or provider complaints. In accordance with 105 CMR 155 et seq (Department of Public Health Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq (Elder Abuse Reporting and Protective Services Program) all reports of abuse, neglect and mistreatment, including restrictive interventions involving an elder, require investigation. As noted in Appendix G-1-e, critical incidents are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to MassHealth. Additionally, EOEA reports and monitors consumer assessment data for any indications of unauthorized use of restrictive interventions.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

EOEA and DPH are the state agencies to receive reports of the unauthorized use of seclusion through protective service reports or provider complaints. Both agencies have state regulations in place which require investigating all reports of abuse and neglect and mistreatment, which would include the unauthorized use of seclusion. These regulations may be found at 105 CMR 155 et seq. (Department of Public Health Patient and Resident Abuse

Prevention, Reporting, Investigation, Penalties, and Registry) and 651 CMR 5.00 et seq. (Elder Abuse Reporting and Protective Services Program). As noted in Appendix G-2-a, critical incidents including the unauthorized use of seclusion, are reported by EOEA to EOHHS in accordance with EOHHS policies and procedures for such reporting. In addition EOEA provides an annual summary report of incidents to MassHealth. Additionally, EOEA reports and monitors consumer assessment data for any indications of unauthorized use of seclusion.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

With the exception of Respite services, waiver participants are served only in their own personal residences. When receiving waiver services in a respite location other than their home, waiver participant medication management is overseen by the entity that certifies or licenses the respite care setting. Medication management responsibilities fall under the Department of Public Health for Hospitals, Rest Homes and Skilled Nursing Facilities. Assisted Living Residences are certified by EOEA. Oversight is provided in accordance with 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and Licensed Practical Nurses). Oversight of Hospitals, Rest Homes, Skilled Nursing Facilities and Assisted Living Residences is conducted every two years.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

State oversight and follow-up of medication management is conducted as part of the licensing or certification process for the applicable respite care setting. Oversight is provided in accordance with 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and practical nurses).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

State oversight and follow-up of medication administration is conducted in accordance with 105 CMR 130.00 (Department of Public Health Hospital Licensure Regulations that describes the standards for the maintenance and operations of hospitals in Massachusetts), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act), and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and Licensed Practical Nurses).

iii. Medication Error Reporting. *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  The Massachusetts Department of Public Health for all DPH licensed facilities and the Executive Office of Elder Affairs for Assisted Living Residences.

  (b) Specify the types of medication errors that providers are required to *record:*

  All medication errors in DPH licensed facilities must be recorded. DPH requires a Medication Occurrence Report when there is an event that results from the breach of one of the 5 “R’s”, namely right individual, right medication, right time, right dose and right route. There are 5 types of reportable occurrences— “the 5 wrongs” are wrong individual, wrong medication (which includes administering medication without an order), wrong time (which includes a forgotten dose), wrong dose and wrong route.

  (c) Specify the types of medication errors that providers must *report* to the State:

Medication Occurrence Reports must be submitted to DPH within 24 hours of the incident for any reportable medication occurrence in a DPH licensed facility. A reportable occurrence is any medication error followed by a medical intervention, illness, injury or death. The DPH maintains a designated 24 hour hotline to receive all Medication Occurrence Reports.

Assisted Living Residences must report any medication error with an adverse effect requiring medical attention.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

State oversight and follow-up of medication administration errors is conducted in accordance with 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure), 105 CMR 150.00 (Department of Public Health regulations governing licensing of long-term care facilities), 105 CMR 158.000 (Department of Public Health Licensure of Adult Day Health Programs), 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts), MGL c. 94C (Massachusetts Controlled Substances Act) and MGL c. 112 s. 74 and 74A (Mass General Laws regarding registration of Registered Nurses and Licensed Practical Nurses).

The Department of Public Health is responsible for oversight of Hospitals and Nursing Facilities. Licenses for these facilities are renewed every two years. In addition, the Department of Public Health conducts investigations into reported complaints, which would include any complaints regarding medication management. The regulation citation is 105 CMR 130.00 (Department of Public Health regulations governing hospital licensure).

Medication management in Assisted Living Residences is overseen by EOEA in accordance with 651 CMR 12.00, the state regulations governing certification of Assisted Living Residences. Assisted Living Residences are re-certified every two years. The regulation citation is 651 CMR 12.00 (EOEA regulations describing certification procedures and standards for Assisted Living Residences in Massachusetts).

In the Hospital, Nursing Facility and Assisted Living settings, oversight of medications is conducted as part of the overall licensure/certification process and includes review of medication administration policies. Through site visits and reviews of medication records, the licensing/certifying State Agencies detect harmful practices and intervene appropriately.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
H&W a1. Waiver participants were assessed to identify concerns of abuse and neglect. Numerator: Number of waiver participants with a documented assessment of abuse and neglect Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

H&W a2. Case management entity staff had Criminal Offender Record Information (CORI) checks at the required times. Numerator: Number of case management entity staff that had CORI checks at the required times Denominator: Number of case management entity staff

Data Source (Select one):
Other
If 'Other' is selected, specify:
CORI Verification Reporting for ASAPs and SCOs

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
H&W a3. Waiver service provider staff had Criminal Offender Record Information (CORI) checks at required times. Numerator: Number of waiver service providers audited whose staff had CORI checks at required times Denominator: Number of waiver service providers audited

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
ASAP and SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
H&W a4. Case management entity staff received training on their responsibilities as mandated reporters of abuse, neglect, exploitation, and unexplained death.
Numerator: Number of case management entity staff that were trained on abuse, neglect, exploitation, unexplained death, and mandated reporter requirements
Denominator: Number of case management entity staff

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:
ASAP and SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
H&W a5. Provider performance monitoring ensured waiver service providers were trained on responsibilities as mandated reporters of abuse, neglect, exploitation & unexplained death. Num: # waiver service provider agencies audited with documented staff training on abuse, neglect, exploitation, unexplained death & mandated reporter requirements Denom: # waiver service provider agencies audited

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:
ASAP and SCO quality reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on

the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
H&W b1. Reported critical incidents affecting waiver participants had action/safety plans implemented, according to applicable EOEA requirements. Numerator: Number of reported critical incidents affecting waiver participants that had action/safety plans implemented, according to applicable EOEA requirements Denominator: Number of reported critical incidents affecting waiver participants

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
ASAP and SCO Incident reporting

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: ASAPs and Senior Care Organizations (SCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
H&W c1. Reported incidents of the unauthorized use of restraints/restrictive interventions had follow-up, according to EOEA requirements. Numerator: Number of reported incidents of the unauthorized use of restraints/restrictive interventions that had follow-up, according to EOEA requirements Denominator: Number of reported incidents of the unauthorized use of restraints/restrictive interventions

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
ASAP and SCO Incident reporting

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: ASAPs and Senior Care Organizations (SCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
H&W d1. Waiver participants were assessed to identify fall risks. Numerator: Number of waiver participants with a documented assessment of fall risk Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
H&W d2. Waiver participants were assessed to identify housing environmental safety risks. Numerator: Number of waiver participants with a documented assessment of housing environmental safety risks Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:

SIMS data report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
H&W d3. Waiver participants were assessed for their ability to manage medications and their need for assistance. Numerator: Number of waiver participants with a documented assessment of their ability to manage medications Denominator: Number of waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
SIMS data reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Analysis of SCO MDS submissions

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The Executive Office of Elder Affairs (EOEA), MassHealth and LTSS are responsible for ensuring effective oversight of the waiver program, including administrative and operational functions performed by the Aging Services Access Points (ASAPs) and Senior Care Organizations (SCOs). In the event problems are discovered with the management of the waiver program, ASAPs/SCOs, or waiver service providers, EOEA/MassHealth/LTSS will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed. Further, EOEA, MassHealth and LTSS are responsible for identifying and analyzing trends related to the operation of the waiver and determining strategies to address quality-related issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the

waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

EOEA's data-focused quality improvement strategy (QIS) is designed to assure that essential safeguards are met with respect to health, safety, and quality of life for waiver participants, A continuous loop of quality management enables the identification of issues, notification to responsible parties, correction/remediation, follow-up, analysis of patterns and trends, and system improvement activities. Quality is tracked through performance measures based on waiver assurances and sub-assurances as well as state law, regulations, and sub-regulatory policies and guidance. These performance metrics measure participant health and safety and other quality-of-life domains, including participant access, person-centered planning, service delivery, rights and responsibilities, and participant satisfaction.

Quality is approached from three perspectives: the participant, the provider, and the system. Each tier focuses on prevention of adverse events, discovery of issues, remediation, monitoring, and system improvement. Information gathered on the participant and provider levels is managed directly by each Aging Services Access Point (ASAP) and Senior Care Organization (SCO); EOEA and MassHealth have oversight responsibilities in the areas of level of care determinations, service plans, qualified providers, health and welfare, administrative authority, and financial accountability to ensure compliance with EOEA's and MassHealth's policies and procedures. Information gathered on the individual and provider levels is used both to remedy situations on those levels, and to inform overall system performance and improvement efforts.

Systems level improvements are organized on two levels—the case management (CM) entity level and system-wide. CM entities, as described in Appendix A, include ASAPs and SCOs, which work most closely with waiver participants and waiver service providers through the service planning and oversight process. Ultimately EOEA and MassHealth are accountable for assuring that identified quality improvement efforts are

implemented and reviewed both within individual ASAPs/SCOs and across the system.

EOEA and MassHealth collaborate to facilitate prevention, discovery, remediation, monitoring, planning, and overall system quality improvement strategies. EOEA staff (Director of Home and Community Programs, Assistant Director of Home and Community Programs, Waiver Program Manager, and Quality Manager) and MassHealth Office of Long Term Services and Supports (LTSS) staff (Director of Coordinated Care and Contract Managers) maintain overall responsibility for designing and overseeing the waiver's QIS and assuring that appropriate data are collected, disseminated, and reviewed and service improvement targets are established.

Tier I – The Participant Level
Activities related to quality oversight at the participant level include reviews within the CM entity and at the state level of level of care, person-centered care plans, timely participant documentation, critical incidents, and investigation and resolution of complaints.

Tier II – The Provider Level
At the provider level, the state ensures that providers are qualified and performing effectively on an on-going basis. SCOs primarily utilize ASAP-procured waiver service providers. The following activities apply to all waiver providers; unless variations are noted below.
- Providers receive onsite audits at least once during the first six months after initial services are delivered, and thereafter once every 2-3 years, depending on provider type, to ensure compliance.
- ASAPs administer annual consumer and staff satisfaction surveys to evaluate provider performance.
- ASAPs maintain a staff/consumer complaint/compliment log as an additional mechanism to gather feedback regarding provider performance.
- SCOs administer an annual SCO-level CAHPS survey to all participants, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor and report the CAHPS results data to LTSS.

Tier III – the System Level
Information from the participant and provider levels informs the third tier of the quality improvement strategy, providing information to enable the state to identify and resolve issues, analyze patterns and trends, and implement system-wide corrections and improvements. Ultimately, this process supports the state's ability to ensure optimal operation of the waiver and to meet the needs of participants.

1. Reports: System-wide reports are generated from both the participant and provider levels, and EOEA and LTSS review and analyze aggregated data to identify issues and trends and to address and improve system-wide performance, service, and satisfaction. Data and reports come from the SIMS client information system, online and Excel reports, as well as from SCO reporting. ASAPs and SCOs review and submit reports, enabling EOEA to undertake systemic review.

2. Ongoing Monitoring and Improvement Projects: EOEA and LTSS perform ongoing monitoring and analysis that informs their efforts to plan and undertake quality improvement projects.

Monthly and yearly monitoring: EOEA monitors measures monthly and/or annually, reviewing both quantitative and qualitative data in SIMS. LTSS monitors SCO performance through similar procedures. The state communicates with its waiver Case Management entities about any problems that are uncovered and manages proper remediation.

Committee and waiver quality improvement: EOEA periodically convenes a project-based quality improvement committee, currently composed of EOEA staff and ASAP representatives, which focuses on sharing best practices and standardizing current procedure to improve quality. EOEA and this Committee research approaches to monitoring and remediating quality, tracking trends, and using quality improvement tools and practices to strengthen the state's ability to meet waiver assurances.

LTSS conducts quarterly meetings with SCO leadership at which waiver quality improvement is a standing agenda item and also holds an annual meeting focused on waiver oversight.

Designation/Contracting reviews: EOEA conducts site visits at each of the ASAPs and LTSS conducts site visits at each of the SCOs once or more during the five-year waiver cycle, reviewing practices on monitoring, remediating, and improving performance on waiver quality measures. Results of the reviews inform the state's

continued contracting with the CM entities, assures appropriate compliance and adherence to requirements, and provides any technical assistance as needed.

In addition, the SCO contract has extensive requirements to assure that a high quality of clinical care and support services are delivered to SCO enrollees, since SCOs must authorize, coordinate, and deliver all levels of primary, acute, preventive, behavioral health, and long-term care, as well as HCBS. SCOs must report to the state and to CMS on a full spectrum of geriatric clinical indicators developed by the National Committee for Quality Assurance (NCQA).

Processes for Trending

EOEA tracks trends on all measures through reports and through the use of quality improvement tools. EOEA tracks data by measure, by ASAP or SCO as well as statewide to identify trends that indicate areas needing additional analysis and scrutiny. Tracking each measure by entity allows EOEA to zero in on a particular problem area to both identify issues within an organization, and to identify a potential problem that requires systemic course correction and/or training. EOEA and LTSS jointly review the quality management data. LTSS communicates all issues and corrective actions to each SCO as appropriate, based on the contract. In addition, EOEA and LTSS closely monitor critical incident data to identify trends, specific areas of concern at the provider and staff level and any clusters of issues.

This ongoing monitoring of the measures enables EOEA to identify which measures are showing lower performance, focus its investigation of the causes and remedies for them, including providing clarity and direction to the system, produce formal guidance documentation, and provide training.

Processes for Prioritizing System Improvements

EOEA has formalized and standardized its processes for identifying and prioritizing system improvements and maintains a catalog of system improvement options. While EOEA conducts monthly and yearly discovery and remediation activities, it updates the catalog, as items are addressed and as new ideas arise. EOEA reviews the catalog at least monthly to ensure that new ideas are recorded and all items prioritized.

When considering an idea for implementation, EOEA asks the following questions:
Does the improvement idea address
• Issues from incident reports?
• Concerns that participants/informal caregivers reported?
• Concerns that ASAPs or SCOs reported?
• Concerns that other stakeholders, such as advocacy groups, reported?
• Other risks to waiver participants, especially health and welfare concerns?
• Low/declining performance on measures?

The criteria on incident reports, concerns of participants/informal caregivers, and risks to participants are weighted the most heavily.

EOEA also considers criteria to assess the feasibility of implementing improvement options, for ASAPs and SCOs, as well as for LTSS and EOEA. The process allows EOEA to systemically assess and prioritize improvement options, and determine implementation timing.

Processes for Implementing System Improvements

EOEA undertakes formal process-improvement projects to ensure organized and structured procedures for implementation of all required system improvements. EOEA bases its methods on tested and well-respected frameworks, such as the Institute for Healthcare Improvement's (IHI's) Model for Improvement, including the Plan Do Study Act (PDSA) process.
EOEA tracks current improvement projects, completed projects, and identifies new projects.
Tracking allows EOEA to maintain a high-level view of all projects and the relationship of systems improvements to the problems being addressed. EOEA follows up to determine the impact that improvement projects have on system quality and whether such projects have the anticipated effects. When outcomes do not demonstrate the planned impact, alternate approaches are considered and implemented. EOEA undertakes the standard PDSA cycle to test different approaches to improvements—planning the test and making predictions,

implementing the test and documenting results, analyzing the results, deciding if something should be changed to achieve the improvement, and planning the next PDSA cycle.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Process for Monitoring and Analyzing the Effectiveness of System Design Changes

MassHealth and EOEA have a strong commitment to a quality improvement system that continuously evaluates the processes in place to monitor waiver activities, participant outcomes, and system design changes. EOEA use elements of such frameworks as the IHI Model for Improvement to conduct certain improvement initiatives, leading to system design changes. EOEA utilizes various tools, such as run or control charts, to evaluate the effectiveness of its improvement initiatives. These charts allow for tracking a performance measure over time, identifying the point in time when an improvement was made, identifying trends and determining whether an initiative successfully addresses improvement goals. Such charts give EOEA the ability to observe performance before and after an improvement was made, to evaluate the effectiveness of the change.

Other methods of determining the effectiveness of system design changes are more qualitative, such as feedback from ASAPs staff, Program Managers and Nurse Managers, at designation reviews and through participant and caregiver feedback. EOEA home care unit meets regularly to discuss specific initiatives and the success or failure of that improvement initiative, as well as meeting routinely with LTSS staff for similar purposes. EOEA may adjust its course of action depending on the results of these discussions.

Roles and Responsibilities

EOEA's Director of Home and Community Programs, the Assistant Director of Home and Community Programs, the Waiver Program Manager, the Quality Manager, and the Director of Home and Community Based Services Policy Lab are responsible for evaluating the processes and systems in place for the waiver program. In addition, the 26 ASAPs conduct their own evaluations, make agency-wide improvements as necessary, and assess these changes, while adhering to program requirements. ASAP quality managers meet every other month to share information and best practices, enhancing quality across the state. Similarly, the MassHealth Office of Long Term Services and Supports reviews quality data that the SCOs provide, and shares all data with EOEA. EOEA and MassHealth review all systemic findings and issues related to ongoing operation of the waiver program. LTSS, with the guidance and direction of EOEA and MassHealth, amends the SCO contract, issues subcontractual guidance and provides technical assistance to the SCO plans as required to ensure adherence to program requirements and implementation of best practices.

EOEA's quality improvement strategy systematically uses the processes of discovery, remediation,

improvement design and implementation, trend identification, and evaluation of design changes to ensure that the 1915(c) Frail Elder Waiver program operates as intended. These continuous quality activities are embedded in all aspects of the operation of the waiver. MassHealth and EOEA have designed an effective quality improvement strategy for the waiver program, which identifies consumer-focused quality indicators and uncovers and evaluates system-wide improvements.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Process to Evaluate the Quality Improvement Strategy

In collaboration with MassHealth, EOEA is committed to the ongoing evaluation of the processes and systems in place that form the quality improvement strategy. EOEA holds annual internal meetings to evaluate the quality improvement strategy, and is in the process of creating an improved tool with which it assesses the waiver QIS. EOEA is developing questions for different members of the team to elicit information from various perspectives on the quality improvement strategy. Through the use of this assessment tool, EOEA will be able to objectively and logically evaluate the strategy, considering all of its aspects.

Though EOEA formally evaluates the quality improvement strategy as a whole once a year, it also considers what might be changed throughout the year and decides on improvement projects as described in the previous section. For example, an ongoing dialogue between EOEA and the ASAPs identified the need for user-friendly, streamlined, and uniform waiver quality measure tracking processes for all ASAPs and for EOEA to use. As a result, EOEA has undertaken the initiative to improve reporting, which is meeting this need, and continually strengthening the overall quality improvement strategy.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Each provider is required to annually submit an independent audit and the Uniform Financial Statements and Independent Auditor's Report (the UFR) to the Commonwealth's Executive Office of Administration and Finance's Operational Services Division. Operational Services Division regulation 808 CMR 1.00, Compliance, Reporting and Auditing for Human and Social Services, is the primary regulation covering contract compliance, financial reporting and auditing requirements for waiver service providers. These regulations are derived from M.G.L. c.29 s.29B, applicable industry auditing and accounting standards set by the American Institute of Certified Public Accountants (AICPA), federal restrictions, the Internal Revenue Service (IRS) and other relevant sources.

(b) The integrity of provider billing data for Medicaid payment of waiver services is managed by ASAP staff utilizing the Senior Information Management System (SIMS) and the Medicaid Management Information System (MMIS). ASAP staff utilize SIMS to confirm the delivery of services, the units of delivered services and the cost of all services prior to submitting claims to Medicaid. SIMS also contains each participant's comprehensive service plan (CSP) and supports the ability to ensure that the services rendered are in accordance with the CSP prior to provider payment. The EOEA hosts, maintains, and has access to all data within SIMS and reviews and approves this data on a monthly basis. MMIS sets payment ceilings to ensure integrity of the payment and also confirms each participant's Medicaid waiver eligibility as a condition of payment.

(c) For members enrolled through a Senior Care Organization (SCO) receiving waiver services from providers participating in the Frail Elder Waiver:
The SCO carries out primary program integrity activities to identify any potential overpayments made to providers due to fraud, waste and abuse. MassHealth's Office of Long Term Services and Supports (LTSS) regularly carries out audits of SCOs against a set of compliance metrics as required in the SCO's contract with EOHHS. In addition, SCOs are required by contract to develop and maintain a comprehensive internal anti-fraud, waste and abuse program plan to detect and prevent fraud, waste, and abuse by providers. Similarly, by contract, and in accordance with 42 CFR 438.608, SCOs must have administrative and management arrangements or procedures, including a mandatory compliance plan,

which are designed to guard against fraud, waste and abuse. Finally, MassHealth has developed system edits within MMIS to deny fee-for-service claims billed for members enrolled in a SCO.

(c) For members served through the ASAPs:
The Executive Office of Health and Human Services is responsible for conducting the financial audit program. The MassHealth Program Integrity Unit oversees rigorous post payment review processes that identify claims that are paid improperly due to fraud, waste and abuse.

MassHealth maintains an interdepartmental service agreement with the University of Massachusetts Medical School's Center for Health Care Financing to carry out post-payment review and recovery activities through its Provider Compliance Unit (PCU).

On a regular basis, PCU runs Surveillance Utilization Review System (SURS) reports to identify aberrant billing practices. MassHealth runs SURS reports and algorithms that examine all provider types such that every provider type is generally being reviewed with a SURS report each year. For example, MassHealth and the PCU run a recurring algorithm that identifies any claims paid for members after their date of death as well as a report that identifies outliers in billing growth by provider type and reports that identify excessive activity, e.g., unusually high diagnosis and procedure code frequencies, by provider as well as “spike” reports that identify providers receiving higher than average payments. On average, MassHealth runs between 30 and 40 algorithms per year and 100 to 120 SURS reports of varying scope (e.g. all provider types, specific provider types, or a single provider) per year. These SURS reports and algorithms are run manually and not on a set schedule. There are no set criteria that must be met prior to MassHealth running particular SURS reports and algorithms.

When MassHealth identifies outliers in SURS reports or algorithms, additional SURS reports or algorithms may be run that are focused on that provider type identifying specific providers with unusual patterns or aberrant practices to enable targeting for additional review, including desk review or on-site audit. Desk reviews and audits are not solely initiated following findings in SURS reports and algorithms and may also be initiated due to a member complaint or a concern raised by the MassHealth program staff.

In addition, MassHealth and PCU regularly develop algorithms that identify duplicative or noncompliant claims for recovery. MassHealth regularly reviews algorithm and SURS report results to identify providers with a large number of noncompliant claims, aberrant billing patterns or excessive billings. Upon discovering such providers, MassHealth and PCU will open desk reviews or on-site audits targeting the provider. The scope and sampling methodology of post-payment reviews will vary from case to case. Algorithms and SURS reports typically review 100% of claims received for a given provider type over a specified timeframe. The sampling process for post-payment review (desk review and on-site audits) entails generating a random sample of all members receiving services over the audit review period. For audits and desk reviews, MassHealth and PCU will perform a random sample of members at a 90% confidence level and review all claims and associated medical records for each member over a specified timeframe (typically 4 to 6 months). A margin of error is calculated and determined only for reviews and audits in which MassHealth intends to extrapolate overpayments based on the findings from the review or audit to the provider’s full census. Where extrapolation may be performed, MassHealth and PCU typically pull a sample of 25 members and use the lower 90% confidence interval amount as the extrapolated overpayment amount to be recouped. The margin of error for the extrapolated amount can vary depending upon the total number of members the provider has served during the audit period. Where the provider has served fewer than 25 members over the audit period, MassHealth and PCU will review all of the members and associated claims, resulting in a margin of error of +/- 0%.

On average, MassHealth and PCU run between 30 and 40 algorithms and SURS reports to identify recoveries as well as target providers for desk reviews and on-site audits. Because SURS reports and algorithms do not always identify providers exhibiting aberrant billing behavior, and because member complaints or program staff concerns are raised on an ad hoc basis, there is no scheduled number of desk reviews or on-site audits to be conducted on a year-to-year basis. When MassHealth identifies findings through SURS reports and algorithms, it is MassHealth practice to conduct a desk review or on-site audit within one month.

As part of its post-payment review activities, MassHealth and PCU regularly carry out desk reviews and on-site audits of providers. When initiating a provider desk review, auditors will request medical records, including individualized plans of care, for a sample of MassHealth members receiving services from the provider and compare them against claims data to ensure all paid claims are supported by accurate and complete documentation. As part of on-site audits, MassHealth and PCU develop an audit scope document that identifies specific regulatory requirements to be reviewed. Based on this scope, PCU will develop an audit tool to record the auditors’ findings related to compliance or noncompliance of each regulatory requirement being reviewed. During their on-site visit, auditors will collect medical

records for a sample of members to review for completeness and accuracy. Finally, to verify that services were rendered, auditors will visit a random sample of member homes, interview the members, and observe living conditions to ensure services are rendered consistently with each member's plan of care. The sampling process for home visits is to select a random sample of three to five members. MassHealth and PCU select a smaller sample size for home visits than for desk reviews due to the logistics of conducting on-site audits within a two to three day timeframe.

Upon completion of an on-site audit or desk review, MassHealth will review the findings of noncompliance, if any, with regulatory requirements and determine whether to issue a notice of overpayment or sanction to the provider, depending on whether the provider was found in violation of applicable regulatory requirements. The notice of overpayment or sanction identifies and explains each instance of noncompliance, and notifies the provider of the associated sanctions and identifies the related overpayments. Within the notice, the provider receives the detailed results of the audit review, including lists of each regulatory requirement, the description of the provider's noncompliance, and the associated sanction or overpayment amount. On a case-by-case basis, MassHealth may meet with the provider to review the audit findings and discuss the appropriate corrective actions.
Providers have the opportunity to appeal MassHealth's determination of sanction or overpayment and dispute the related findings. While the appeal is processed, MassHealth will withhold the identified amount of identified overpayments or impose sanctions of administrative fines from future payments to the provider. If the sanctions or overpayment determinations are not appealed, MassHealth will work with the provider to establish a payment plan where a percentage of the overpayment amount is withheld from future payments of the provider's claims until the entire balance of the overpayment or sanction of administrative fines have been recouped.

As a result of a desk review or on-site audit, MassHealth may also require the provider to submit a plan of correction and may identify the provider to be re-audited after a specified period of time (e.g., 6 months) to ensure corrections are made.

Unlike desk reviews and on-site audits where reviewers are manually reviewing claims for a sample of members over a four to six month time period, algorithms and SURS reports generally look back over a longer timeframe up to five years for all claims associated with one or more provider types.

In addition to the activities described above, MassHealth maintains close contact with the attorney general's Medicaid Fraud Division (MFD) to refer potentially fraudulent providers for MFD review and to ensure MassHealth is not pursuing providers under MFD's review.

KPMG is the contractor that performs the Single State Audit for the Commonwealth of Massachusetts.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA a1. Services were billed in accordance with established waiver service payment rates. Numerator: Processed MMIS claims for waiver participants Denominator: Total service claims submitted for waiver participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
Reports from SIMS and MMIS data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
FA b1. Provider payment rates were consistent with the state's rate methodology. Numerator: Number of payment rates, by service type, that were set in accordance with the state's rate methodology Denominator: Number of provider payment rates, by service type

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:
Reports from SIMS and MMIS data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

For all fee-for-service (FFS) claims, the Aging Services Access Points (ASAPs) are responsible for ensuring that provider billing is in accordance with the services authorized in the service plan and that services are billed in accordance with the contracted rate for the service provided. If any discrepancy is noted the ASAP will report the error to the service provider and the services will only be claimed upon reconciliation of the discrepancy. Claims that cannot be reconciled will be reported by the ASAP to the Executive Office of Elder Affairs (EOEA) and MassHealth. If the ASAP or EOEA identify any pattern of problems with provider

billing, EOEA/MassHealth will ensure that a corrective action plan is created, approved, and implemented within appropriate timelines. Timelines for remediation will be dependent on the nature and severity of the issue to be addressed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates for each waiver service in the Frail Elder Waiver are established in one the following ways:

1. For waiver services for which there is a comparable Medicaid State Plan rate, payment for waiver services is made at the comparable State Plan rate pursuant to MGL Chapter 118E, Sections 13C (Establishment of rates of payment for health care services) and 13D (Duties of ratemaking authority; criteria for establishing rates) and regulations governing those specific rates as cited below. Medicaid State Plan rates are developed using provider cost data submitted to the Center for Health Information and Analysis (CHIA) in accordance with provider cost reporting requirements under 957 CMR 6.00: Cost Reporting Requirements. The provider cost data is used to calculate rates that meet the statutory rate adequacy requirements noted above (i.e. payments consistent with efficiency, economy, and quality of care, etc.). There are no differences in the rate methodology between these State Plan and waiver

services. No additional cost adjustment factor (CAF) was used for the waiver services which use the comparable State Plan rate. This applies to the following waiver services:

- Complex Care Training and Oversight, Home Health Aide, and Home Safety/Independence Evaluation (set in accordance with 101 CMR 350: Home Health Services)

State law requires that rates established by EOHHS for health services must be "adequate to meet the costs incurred by efficiently and economically operated facilities providing care and services in conformity with applicable state and federal laws and regulations and quality and safety standards and which are within the financial capacity of the commonwealth." See MGL Chapter 118E Section 13C.

In establishing rates for health services, EOHHS is required by statute to complete a public process that includes issuance of a notice of the proposed rates with an opportunity for the public to provide written comment, and EOHHS is required to hold a public hearing to provide an opportunity for the public to provide oral comment. See MGL Chapter 118E Section 13D (Duties of ratemaking authority); see also MGL Chapter 30A Section 2 (Regulations requiring hearings). The purpose of this public process is to ensure that the public (and in particular, providers) are given advance notice of proposed rates and the opportunity to provide feedback, both orally and in writing, to ensure that proposed rates meet the statutory rate adequacy requirements noted above.

All rates established in regulation by EOHHS are required by statute to be reviewed biennially and updated as applicable, to ensure that they continue to meet the statutory rate adequacy requirements. See MGL Chapter 118E Section 13D (Duties of ratemaking authority; criteria for establishing rates).

2. For waiver services with no comparable State Plan or EOHHS rate, each ASAP negotiates a market rate price with its contracted providers for services provided through the Elder Affairs Home Care Program. The Home Care Program is a large state-funded program serving up to 60,000 elders in the Commonwealth. Each ASAP negotiates the rates for the purchase of services from contracted providers for all elders enrolled in the Home Care program, including the subset of elders participating in the Frail Elder Waiver. Rates are negotiated leveraging the relative market power of this large program and leading to efficiencies and economies of scale. Utilizing this approach ensures that the rates paid for Frail Elder Waiver services are at the market rate for similar services (i.e., the rates paid by ASAPs under the Home Care Program).

For Homemaker, Personal Care, and Supportive Home Care Aide waiver services, which represent the majority of service utilization in this waiver, ASAPs must follow EOEA-issued written guidance for determining the rates, which guidance specifies the cost factors that must be taken into account in establishing these rates for the Home Care program (Notice of Intent to Contract (NOI) and NOI Administrative Overview). Such cost factors include base wages, employee benefit compensation (holiday, sick, personal, vacation, bereavement pay), travel expense, day care, training wages, administrative costs and overhead. In addition, for all services with no comparable State Plan or EOHHS rate, a standardized, formal process consistent with sub-regulatory requirements in EOEA Program Instruction PI #94-11 (Non-Homemaker Purchased Services/Determination of Rates) is required by EOEA through its contracts with the ASAPs. While rates for such services are not directly established by state law, these rates are influenced and informed by legislative mandates regarding direct service worker salary requirements. All rates in this category are reviewed and renegotiated by the ASAP annually. On at least an annual basis EOEA monitors the rates. EOEA's ongoing rate monitoring evidences little variation in rates by service across the state. Through the ASAP rate negotiation process, the state seeks to ensure optimal availability and provision of services while allowing ASAPs the flexibility to reflect geographic cost variables such as variations in transportation costs, labor costs, and ability to hire sufficient staff with appropriate language and cultural competence. Upon successful contract negotiation, the related service rates are entered into the Senior Information Management System (SIMS) and are available for EOEA review. This approach applies to the following waiver services:

- Alzheimer's/Dementia Coaching
- Chore
- Companion
- Enhanced Technology/Cellular PERS
- Evidence Based Education Programs
- Goal Engagement Program
- Grocery Shopping and Delivery
- Home Based Wandering Response Systems
- Home Delivered Meals
- Home Delivery of Pre-packaged Medication
- Homemaker
- Home Safety/Independence Evaluation

- Laundry
- Medication Dispensing System
- Personal Care
- Respite
- Supportive Day Program
- Supportive Home Care Aide
- Transportation

ASAPs negotiate a market rate price as well as a provision for discounting rates for personal care and homemaking waiver services for situations in which there is high volume of hours provided within a site in which there are several waiver participants, such as in an elderly housing complex.

3. Payment rates for Orientation and Mobility services are based on the historic rate for such services from 101 CMR 356.00: Rates for Money Follows the Person Demonstration Services, consistent with other Massachusetts HCBS waivers.

4. For Peer Support, the waiver service rate was set at the comparable EOHHS Purchase of Service (POS) rate (101 CMR 414.00: Rates for Family Stabilization Services) as established in regulation after public hearing pursuant to MGL Chapter 118E, Sections 13C (Establishment of rates of payment for health care services) and 13D (Duties of ratemaking authority; criteria for establishing rates). All POS rates are established in regulation pursuant to this statutory requirement. POS rates are developed using Uniform Financial Reporting (UFR) data submitted to the Massachusetts Operational Services Division, in accordance with UFR reporting requirements under 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services. EOHHS uses UFR data to calculate rates that meet statutory adequacy requirements described above. No productivity expectations and administrative ceiling calculations were used in establishing these rates. UFR data demonstrates expenses of providers of a particular service for particular line items. Specifically, UFRs include line items such as staff salaries; tax and fringe benefits; expenses such as training, occupancy, supplies and materials, or other expenses specific to each service; and administrative allocation. EOHHS uses these line items from UFRs submitted by providers as components in the buildup for the rates for particular services by determining the average for each line item across all providers. In determining the rates for Peer Support, EOHHS used the most recent complete state fiscal year UFR available and determined the average across providers of that service for each line item, which are then used to build each rate.

5. Purchase of goods as waiver services are paid according to the cost of the good. This approach applies to the following waiver services:
- Transitional Assistance Service
- Environmental Accessibility Adaptations

6. Capitation rates for the Senior Care Options managed care program (SCO) are set by MassHealth based on actuarially sound Medicaid capitation rate ranges developed by the state's actuarial firm, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC.

The primary data source used in the SCO capitation rate range development process is Medicaid FFS data for populations similar to SCO enrollees in addition to SCO experience data. The base data, collected directly from Medicaid's MMIS, includes claims and eligibility data. MassHealth and Mercer perform significant data analysis in order to develop base data that represents an actuarially-equivalent, non-enrolled population. In preparing the actuarially sound capitation rate ranges Mercer utilizes enrollment, eligibility, claim, reimbursement level, benefit design, financial data and other information provided by MassHealth and the SCO plans.

No adjustments are made to the base data for non-State Plan services. The substitution of approved services approach was described and discussed at the CMS Medicaid Managed Care Rate Setting conference in Baltimore, Maryland on October 25, 2002. Subsequently, the CMS regional office in Boston had provided guidance indicating that this adjustment was not necessary for the SCO Medicaid capitation rates, as long as enrollees are not receiving HCBS waiver services on a FFS basis while also receiving services from the SCO. This is the case in the MassHealth SCO program.

All Frail Elder Waiver participants choosing to enroll in SCO fall within a Community NHC rating category. This rating category covers enrollees residing in the community who are at nursing home level of care.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly

from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The flow of billing for waiver services delivered to participants who are not enrolled in a SCO is through an intermediary, the Aging Services Access Point (ASAP). The ASAP receives waiver billing from the provider and compares billing with the participant's person-centered comprehensive service plan, approved service contract rate, and units utilizing the participant database, Senior Information Management System (SIMS). The ASAP submits claims to the state's MMIS via SIMS. On a routine/monthly basis, the claim data is electronically submitted to MMIS for claim editing and processing. Providers may bill the state directly.

SCOs may contract either with ASAPs or with individual community service providers for HCBS (waiver) services. In either case, the SCO primary care team must coordinate and authorize all medical and waiver services for each SCO enrollee.

If the SCO has a contract with an ASAP that includes the arrangement of services, the ASAP uses its existing community service network to provide the services to SCO members in accordance with each member's plan of care, and bills the SCO according to the terms of its contract. The ASAP receives payment from the SCO and pays its network providers according to its subcontracts. When the SCO has an arrangement with individual service providers, those providers bill the SCO directly for the services under the terms of their contracts.

The SCO receives an all-inclusive Medicaid capitation payment from the state, and is responsible for payment and delivery of all waiver services.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The ASAPs verify and confirm MassHealth eligibility routinely; at a minimum, monthly. The Medicaid Management Information System (MMIS) maintains date specific eligibility on Medicaid waiver participants. Only service claims for clients whose MassHealth waiver eligibility is verified are submitted for payment processing. MMIS also maintains eligibility data to ensure that a client is enrolled in a Medicaid waiver program prior to payment of claims. The Senior Information Management System (SIMS) verifies all provider invoices prior to payment to ensure that services delivered are in the approved Comprehensive Service Plan and do not exceed the authorized amount of service and contractual service rate. These MMIS and SIMS checks occur in the billing validation process, and result in the removal of any inappropriate billings, prior to the calculation of FFP.

For Waiver Services Delivered to Participants Enrolled in SCO:
The SCO plans receive daily eligibility and enrollment files which enable the SCO plans to validate waiver eligibility. Additionally, all SCO plans have appropriate systems in place to ensure waiver claims are authorized and approved prior to payment. The SCOs verify that all waiver services delivered are in the approved Comprehensive Service Plan and do not exceed the authorized amount.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

ASAPs are reimbursed by EOEA based upon a participant's enrollment in the program and receipt of services. Payments to ASAPs are made through the state accounting system (MMARS). Direct service providers (ex. homemaker agencies) are reimbursed by the ASAP on a monthly basis subsequent to the provision of services, the confirmation that services are consistent with the Comprehensive Service Plan, and upon receipt of an invoice. SIMS maintains the audit trail for services provided and claimed for Federal Financial Participation.

Direct billing instructions are provided upon request.

- [x] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

The SCO processes claims for waiver service to the billing provider via a standard 837 claims transaction.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (•) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS.

Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ( ) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ( ) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- (●) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health**

plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

(a) The SCO program, implemented in partnership with the Centers for Medicare & Medicaid Services, delivers and coordinates all Medicare and Medicaid covered services, including all Frail Elder Waiver services, for eligible Massachusetts seniors managed through a geriatric model of care using Senior Care Organizations contracted under the provisions of Sections 1915(a) and 1932 of the Social Security Act, as described in the Massachusetts Title XIX State Plan. See, TN 04-003. Waiver participants age 65 or older may voluntarily elect to receive all waiver and all Medicare and Medicaid covered services through a SCO. (b) SCO services are currently available in all counties except Dukes and Nantucket counties. (c) All waiver services and all State Plan MassHealth services are furnished by the SCO network of providers. (d) The SCO receives an all-inclusive Medicaid capitation payment from the state. SCOs are approved Medicare Advantage-Part D Special Needs Plans. In addition to Medicaid capitation payments, SCOs receive Medicare capitation payment for each dual eligible beneficiary in accordance with their contracts with CMS. SCOs do not provide waiver services to SCO enrollees on a fee for service basis as all SCO contracts are capitation based. All SCO contracts and SCO capitation payments meet the requirements for risk contracts within the meaning of 42 CFR Part 438.

- ○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ○ **This waiver is a part of a concurrent □1115/□1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The □1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- ☑ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

As specified in Appendix C waiver services are provided in residential settings other than the personal home of the individual only on a respite basis.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
  - **i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13306.76	14646.74	27953.50	49203.70	1744.38	50948.08	22994.58
2	13536.30	14943.68	28479.98	50201.22	1779.74	51980.96	23500.98
3	13765.47	15246.09	29011.56	51217.11	1815.76	53032.87	24021.31
4	13918.50	15553.50	29472.00	52249.80	1852.37	54102.17	24630.17
5	14056.68	15865.40	29922.08	53297.57	1889.52	55187.09	25265.01

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	19200	19200
Year 2	19400	19400
Year 3	19600	19600
Year 4	19800	19800
Year 5	20000	20000

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants

in item J-2-a.

All estimates are derived from the Waiver Year (WY) 2016 CMS-372 for the Frail Elder Waiver MA.0059 for WY1.

The Average Length of Stay (ALOS) reflects the weighted average ALOS data from waiver participants enrolled in the Fee-For-Service (FFS) system and enrolled in SCO in WY 2016. Changes in the estimated ALOS throughout the waiver renewal period result from shifts in the projected proportion of FFS- and SCO-enrolled waiver participants from year to year. Thus the average length of stay during the five-year waiver renewal period is estimated as follows: 280.99 (WY1); 280.79(WY2); 280.58 (WY3); 280.35 (WY4); 280.09 (WY5).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D costs are based on the following:

- Number of Users:
The estimated number of users for each waiver service, except those noted below, is based on actual utilization data for the Frail Elder Waiver in prior waiver years. For most services, service utilization was based on the number of users reported on the Waiver Year 2016 CMS-372 report. For Home Based Wandering Response System, of which there was no utilization in 2016, the estimate of 10 new users per year is based on consultation with state agency program staff and anticipated need. For new waiver services, the estimated number of users is estimated as described below for these services. The Home Care Program serves approximately 60,000 elders in the Commonwealth, and as such is a valuable indicator of need and uptake of services in the FEW. The state agency staff consulted in the development of these estimates are staff within the Executive Office of Elder Affairs Home Care Unit, with extensive knowledge of and access to data on utilization and expenditures in the Home Care Program:

- Cellular PERS: based on February 2018 utilization data from a similar population in the Commonwealth's state-funded Home Care Program, and consultation with state agency program staff, estimated at 4% of the enrolled FFS waiver population in WY1 and adding an additional 2% in each subsequent waiver year. (Data from the analogous state-funded program that serves a similar, non-waiver population was used as a reference point for WY1 to approximate existing need in the current waiver population, but was adjusted down to account for ramp-up in the first year the service is available. In subsequent years, the state estimated growth at 2% per year to account for new waiver participants who will need the service as well as existing participants who develop a need for this service.)

- Evidence Based Education Program: based on consultation with state agency program staff, programmatic goals, and utilization of this service by a similar population in the Commonwealth's state-funded Home Care Program, estimated at 2% of the enrolled FFS waiver population in WY1, 3% in WY2, 4% in WY3, 6% in WY4, and 8% in WY5. (Based on current utilization of this service in the analogous state-funded program that serves a similar, non-waiver population, and interest across the statewide ASAP network consisting of 26 ASAPs statewide, the state estimated approximately 10 users per ASAP in WY1. Expressed as a percent of the total FEW slot capacity, this was rounded up to 1% utilization, with projected growth in subsequent waiver years based on expected uptake and EOEA programmatic goals.)

- Goal Engagement Program: based on information provided by state agency program staff, anticipated need and programmatic goals, estimated at 1% in WY1, 2% in WY2, and 3% in WY3-5. (There is no comparable service in the Commonwealth currently. The WY1 and growth estimates are strictly based on anticipated need and EOEA programmatic goals; out-of-state programs were not utilized to develop the service estimates. The state estimated an average of 25 users at each of the 26 ASAPs in WY1, reflecting anticipated need among the existing FEW population. Expressed as a percent of the total FEW slot capacity, this was rounded up to 2% utilization.)

- Orientation and Mobility Services: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data reported in the WY 2016 CMS-372 report for MA.1027), anticipated need, and programmatic goals, estimated at 10 users in WY1, 20 users in WY2, 30 users in WY3, 40 users in WY4, and 50 users in WY5. (As noted, the state used utilization data from its MFP-CL waiver reference point for WY1, but increased the estimate to account for the somewhat greater anticipated need in the FEW, inherent to the older population. As a result, we estimated 10 users in WY1, 20 users in WY2, 30 users in WY3, 40 users in WY4, and 50 users in WY5. The modest projected growth reflects EOEA's programmatic goals in serving elders who experience vision loss as they age.)

- Peer Support: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data reported in the WY 2016 CMS-372 report for MA.1027), anticipated need, and programmatic goals, estimated at 1% in WY1, 2% in WY2, and 3% in WY3-5. (As noted, the state used MFP-CL data as a reference point for the WY1 estimate, but increased the estimate to 1% of the total FEW slot capacity in WY1 to reflect anticipated need among the existing FEW population, with growth anticipated in alignment with EOEA's programmatic goal of increasing uptake of the service to address unmet needs of participants with behavioral health needs.)

The estimated number of users per year for participants enrolled in SCO, the managed care delivery system, is based on actual enrolled members for the base year of 2016, and trended forward based on actual SCO-FEW enrollment growth in Waiver Years 2014 – 2016.

- Average Units per User:
The average units per user for all waiver services except those noted below are based on actual utilization for the Frail Elder Waiver, as reflected on the WY 2016 CMS-372 report. For Home Based Wandering Response System, of which there was no utilization in 2016, average units per user is estimated as one installation per user and ongoing monthly utilization based on the average length of stay for the waiver population. For new waiver services, average units per user is estimated as described below for each of these services. The Home Care Program serves approximately 60,000 elders in the Commonwealth, and as such is a valuable indicator of need and uptake of services in the FEW. When the same service is available in FEW and the Home Care Program, the same rate is used in both. The state agency staff consulted in the development of these estimates are staff within the Executive Office of Elder Affairs Home Care Unit, with extensive knowledge of and access to data on utilization and expenditures in the Home Care Program.

- Cellular PERS: one installation per user; ongoing monthly utilization based on the average length of stay for the waiver population. (Each user of this service would require only one PERS installation, while monthly maintenance fees would be ongoing and monthly, annualized at 12 units per user per year. The estimate for the monthly maintenance fee units per user was adjusted for the average length of stay.)

- Evidence Based Education Program: based on consultation with state agency program staff, programmatic goals, and utilization of this service by a similar population in the Commonwealth's state-funded Home Care Program, estimated at 12 classes (which represents 6 classes each of two courses) per year (see service limit description in Appendix C-1/C-3). (The estimate of 12 classes per year reflects state agency staff's expectation, based on utilization of this service across the ASAP network, that waiver participants who use this service would take no more than two courses per year and attend six classes per course.)

- Goal Engagement Program: based on information provided by state agency program staff, anticipated need and programmatic goals, estimated at one episode per year (see service limit description in Appendix C-1/C-3). (Where this is a comprehensive service, and the unit type (per episode) encompasses up to 10 in-home visits by the OT or RN and up to $1,800 in purchases related to home safety, minor home repairs, and related items and services, the state set a service limit of one episode per participant per year. The average units per user reflects this service limit as described in Appendix C-1/C-3.)

- Orientation and Mobility Services: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data in the WY 2016 CMS-372 report for MA.1027) and anticipated need, and adjusted for the ALOS in this waiver, estimated at 15 units per year. (The state referenced utilization experienced in the MFP-CL waiver starting point to estimate units per user, and adjusted for the average length of stay in the FEW. The estimate of fifteen 15-minute units per user per year represents 1-2 visits for assessment and training, totaling 3.75 hours.)

- Peer Support: based on experience in the Massachusetts MFP-CL HCBS waiver (MA.1027) in MFP-CL Waiver Year 2016 (reflected in claims data in the 2016 CMS-372 report for MA.1027) and anticipated need, and adjusted for the ALOS in this waiver, estimated at 529 units per year. (To estimate average units per user in WY1, the state used utilization in the MFP-CL waiver as reflected in claims data for MFP-CL WY2016 and adjusted for the ALOS in the FEW. The estimated 529 average 15-minute units per user represents approximately 3.3 hours per week.)

Average Cost per Unit:
Except as noted below, the average cost per unit for all waiver services is based on claims data from Waiver Year 2016 reflected in the WY 2016 CMS-372 report. For Home Based Wandering Response System, for which there were no waiver service claims in WY 2016, average cost per unit for both installation and monthly fee are based on the average cost per unit of this service in the state-funded Home Care program at the time of this submission. For new waiver services, average cost per unit is estimated as follows:

- Cellular PERS (installation and monthly fee): This service is currently available in the state-funded Home Care program. The estimated average cost per unit reflects Home Care program expenditure data.

- Evidence Based Education Program: This service is currently available in the state-funded Home Care Program. The average cost per unit reflects current per-class costs.

- Goal Engagement Program: There is currently no comparable service in the Commonwealth; however this service will be implemented concurrently in the state-funded Home Care Program. The cost per unit for this service reflects the anticipated rate for this service in the Home Care Program.

- Orientation and Mobility Services: This service is currently available in the Massachusetts MFP-CL Waiver (MA.1027). The average cost per unit is based on the actual average per unit rate for Orientation and Mobility Services as reflected in claims data in the WY 2016 CMS-372 report for the MFP-CL Waiver, which was the most recently-accepted 372 report for that waiver at the time of the submission of the FEW renewal application.

- Peer Support: This service is currently available in the Massachusetts MFP-CL Waiver (MA.1027). The average cost per unit is based on the actual average per unit rate for Peer Support as reflected in claims data in the WY 2016 CMS-372 report for the MFP-CL Waiver, which was the most recently-accepted 372 report for that waiver at the time of the submission of the FEW renewal application.

For members enrolled in SCO, the total cost of services included in capitation was determined using capitation rates developed by the state's actuarial firm, Mercer Health and Benefits, LLC (Mercer) for Community Long-Term Care. To determine the total cost of services included in capitation, the Calendar Year 2018 rates were adjusted to account for the portion designated to cover waiver services.

The Factor D was determined by dividing the total projected costs of service for both FFS and SCO by the total projected enrollment for both in each respective waiver year.

Trend:
The rates described above were trended forward annually to WY 2019, as well as for subsequent waiver years, by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018).

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' costs are based on WY 2016 utilization of all other Medicaid services (D') by MA.0059 Waiver participants as reported on the 2016 CMS-372. The Factor D' reflected on the WY 2016 372 is comprised of both the FFS and SCO Average Per Capita Other Medicaid Expenditures. The annualized value of Factor D' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor D' was multiplied by the average length of stay and divided by 365.

In addition, WY 2016 costs were trended forward annually 2.1%, the Consumer Price Index – All Urban

Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018) to estimate Factor D' for WY 2019 (WY 1), as well as for subsequent waiver years.

The calculation for Factor D' in WY1, therefore, is as follows:
Step1: Annualize the WY 2016 Factor D'
WY 2016 Annualized D' = WY 2016 Factor D' x (365 ÷ WY 2016 ALOS)

Step 2: Trend forward and de-annualize to estimate Factor D' for WY1
WY1 D' = [WY 2016 Annualized D' x (WY1 ALOS ÷ 365)] x 1.021^3

As Factor D' costs are based on WY 2016 data, the cost and utilization of prescription drugs in the base data reflects the full implementation of Medicare Part D. Therefore no Medicare Part D drug costs or utilization are included in the Factor D' estimate.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G costs are based on the facility component (G) costs for WY 2016 as reported on the 2016 CMS-372 for Waiver MA.0059.

Factor G on the 2016 CMS-372 was derived from the cost per member for MassHealth members who resided in a nursing facility in WY 2016. Actual costs were included for all members who were in a facility for at least 180 continuous days (a long-stay), although only the claims that occurred during WY 2016 for the period of facility stays were included in the set. The annualized value of Factor G is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor G was multiplied by the average length of stay and divided by 365.

In addition, WY 2016 costs were trended forward annually by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018) to estimate Factor G for WY 2019 (WY 1), as well as for subsequent waiver years.

The calculation for Factor G in WY1, therefore, is as follows:
Step1: Annualize the WY 2016 Factor G
WY 2016 Annualized G = WY 2016 Factor G x (365 ÷ WY 2016 ALOS)

Step 2: Trend forward and de-annualize to estimate Factor G for WY1
WY1 G = [WY 2016 Annualized G x (WY1 ALOS ÷ 365)] x 1.021^3

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' costs are based on the utilization of all Medicaid services (G') in WY 2016 for MassHealth members residing in a nursing facility in a long-stay as reported on the CMS-372 for the Frail Elder Waiver as described above. The annualized value of Factor G' is adjusted by the average length of stay used for Factor D to make the period of comparison comparable as follows: the annualized value of Factor G' was multiplied by the average length of stay and divided by 365.

In addition, WY 2016 costs were trended forward annually by 2.1%, the Consumer Price Index – All Urban Consumers: U.S. City Average (Medical care services, Unadjusted 12-mos. ended March 2018) to estimate Factor G' for WY 2019 (WY 1), as well as for subsequent waiver years.

The calculation for Factor G' in WY1, therefore, is as follows:
Step1: Annualize the WY 2016 Factor G'
WY 2016 Annualized G' = WY 2016 Factor G' x (365 ÷ WY 2016 ALOS)

Step 2: Trend forward and de-annualize to estimate Factor G' for WY1
WY1 G' = [WY 2016 Annualized G' x (WY1 ALOS ÷ 365)] x 1.021^3

Appendix J: Cost Neutrality Demonstration

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Alzheimer's/Dementia Coaching
Home Health Aide
Homemaker
Personal Care
Respite
Chore
Companion
Complex Care Training and Oversight (formerly Skilled Nursing)
Enhanced Technology/Cellular Personal Emergency Response System (PERS)
Environmental Accessibility Adaptation
Evidence Based Education Programs
Goal Engagement Program
Grocery Shopping and Delivery
Home Based Wandering Response Systems
Home Delivered Meals
Home Delivery of Pre-packaged Medication
Home Safety/Independent Evaluations (formerly Occupational Therapy)
Laundry
Medication Dispensing System
Orientation and Mobility Services
Peer Support
Senior Care Options (SCO)
Supportive Day Program
Supportive Home Care Aide
Transitional Assistance
Transportation

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia Coaching Total:							12584.25

Alzheimer's/Dementia Coaching		Visit	75	1.00	167.79	**12584.25**	
Home Health Aide Total:							**83832148.62**
Home Health Aide		15 min	3947	3366.00	6.31	**83832148.62**	
Homemaker Total:							**48947733.39**
Homemaker		15 min	10709	753.00	6.07	**48947733.39**	
Personal Care Total:							**66325113.60**
Personal Care		15 min	7188	1580.00	5.84	**66325113.60**	
Respite Total:							**137783.80**
Respite		Install	46	11.00	272.30	**137783.80**	
Chore Total:							**1058924.46**
Chore		15 min	1221	103.00	8.42	**1058924.46**	
Companion Total:							**10322856.18**
Companion		15 min	2583	809.00	4.94	**10322856.18**	
Complex Care Training and Oversight (formerly Skilled Nursing) Total:							**1276857.60**
Complex Care Training and Oversight (formerly Skilled Nursing)		Visit	2336	6.00	91.10	**1276857.60**	
Enhanced Technology/Cellular Personal Emergency Response System (PERS) Total:							**216608.73**
Cellular PERS - Install		Install	663	1.00	39.34	**26082.42**	
Cellular PERS - Monthly		Monthly	663	9.00	31.93	**190526.31**	
Environmental Accessibility Adaptation Total:							**691260.28**
Environmental Accessibility Adaptation		Item	1973	2.00	175.18	**691260.28**	
Evidence Based Education Programs Total:							**202770.60**
Evidence Based Education Programs		Class	331	12.00	51.05	**202770.60**	
Goal Engagement Program Total:							**565372.76**
Goal Engagement Program		Episode	166	1.00	3405.86	**565372.76**	
Grocery Shopping and Delivery Total:							**171505.95**
Grocery Shopping and Delivery		Order	341	21.00	23.95	**171505.95**	
Home Based Wandering Response Systems Total:							**3640.60**
Home Based Wandering Response		Install				**393.40**	

Systems - Install	☐		10	1.00	39.34		
Home Based Wandering Response Systems - Monthly	☐	Monthly	10	9.00	36.08	**3247.20**	
Home Delivered Meals Total:							**8869490.00**
Home Delivered Meals	☐	Meal	7870	161.00	7.00	**8869490.00**	
Home Delivery of Pre-packaged Medication Total:							**8669.16**
Home Delivery of Pre-packaged Medication	☐	Monthly	46	9.00	20.94	**8669.16**	
Home Safety/Independent Evaluations (formerly Occupational Therapy) Total:							**5153.04**
Home Safety/Independent Evaluations (formerly Occupational Therapy)	☐	Visit	68	1.00	75.78	**5153.04**	
Laundry Total:							**1595716.08**
Laundry	☐	Order	2031	28.00	28.06	**1595716.08**	
Medication Dispensing System Total:							**169359.77**
Medication Dispensing System - Install	☐	Install	31	1.00	51.69	**1602.39**	
Medication Dispensing System - Monthly	☐	Monthly	497	7.00	48.22	**167757.38**	
Orientation and Mobility Services Total:							**4953.00**
Orientation and Mobility Services	☐	15 min	10	15.00	33.02	**4953.00**	
Peer Support Total:							**624357.54**
Peer Support	☐	15 min	166	529.00	7.11	**624357.54**	
Senior Care Options (SCO) Total:							**15381878.40**
Senior Care Options (SCO)	☑	PMPM	2631	9.00	649.60	**15381878.40**	
Supportive Day Program Total:							**33260.04**
Supportive Day Program	☐	15 min	33	37.00	27.24	**33260.04**	
Supportive Home Care Aide Total:							**14562318.16**
Supportive Home Care Aide	☐	15 min	698	3028.00	6.89	**14562318.16**	
Transitional Assistance Total:							**171.34**
Transitional Assistance	☐	Episode	2	1.00	85.67	**171.34**	
Transportation Total:							**469307.78**
Transportation - one-way trip	☐	One-Way Trip	905	12.00	38.17	**414526.20**	
Transportation - per							

mile	☐	Mile	262	103.00	2.03	**54781.58**	

GRAND TOTAL:	**255489795.13**
Total: Services included in capitation:	15381878.40
Total: Services not included in capitation:	240107916.73
Total Estimated Unduplicated Participants:	**19200**
Factor D (Divide total by number of participants):	**13306.76**
Services included in capitation:	801.14
Services not included in capitation:	12505.62
Average Length of Stay on the Waiver:	281

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia Coaching Total:							**12676.94**
Alzheimer's/Dementia Coaching	☐	Visit	74	1.00	171.31	**12676.94**	
Home Health Aide Total:							**85104059.04**
Home Health Aide	☐	15 min	3926	3366.00	6.44	**85104059.04**	
Homemaker Total:							**49725258.60**
Homemaker	☐	15 min	10651	753.00	6.20	**49725258.60**	
Personal Care Total:							**67320703.20**
Personal Care	☐	15 min	7149	1580.00	5.96	**67320703.20**	
Respite Total:							**140678.12**
Respite	☐	Per diem	46	11.00	278.02	**140678.12**	
Chore Total:							**1076247.00**
Chore	☐	15 min	1215	103.00	8.60	**1076247.00**	
Companion Total:							**10474737.84**
Companion	☐	15 min	2569	809.00	5.04	**10474737.84**	
Complex Care Training and Oversight (formerly Skilled Nursing) Total:							**1296931.44**
Complex Care							

Training and Oversight (formerly Skilled Nursing)		Visit	2324	6.00	93.01	**1296931.44**	
Enhanced Technology/Cellular Personal Emergency Response System (PERS) Total:							**304602.30**
Cellular PERS - Install		Install	330	1.00	40.17	**13256.10**	
Cellular PERS - Monthly		Monthly	993	9.00	32.60	**291346.20**	
Environmental Accessibility Adaptation Total:							**702204.36**
Environmental Accessibility Adaptation		Item	1963	2.00	178.86	**702204.36**	
Evidence Based Education Programs Total:							**308967.36**
Evidence Based Education Programs		Class	494	12.00	52.12	**308967.36**	
Goal Engagement Program Total:							**1147535.40**
Goal Engagement Program		Episode	330	1.00	3477.38	**1147535.40**	
Grocery Shopping and Delivery Total:							**174059.55**
Grocery Shopping and Delivery		Order	339	21.00	24.45	**174059.55**	
Home Based Wandering Response Systems Total:							**7032.90**
Home Based Wandering Response Systems - Install		Install	10	1.00	40.17	**401.70**	
Home Based Wandering Response Systems - Monthly		Monthly	20	9.00	36.84	**6631.20**	
Home Delivered Meals Total:							**9011202.20**
Home Delivered Meals		Meal	7828	161.00	7.15	**9011202.20**	
Home Delivery of Pre-packaged Medication Total:							**8851.32**
Home Delivery of Pre-packaged Medication		Monthly	46	9.00	21.38	**8851.32**	
Home Safety/Independent Evaluations (formerly Occupational Therapy) Total:							**5261.16**
Home Safety/Independent Evaluations (formerly Occupational Therapy)		Visit	68	1.00	77.37	**5261.16**	
Laundry Total:							**1620444.00**
Laundry		Order	2020	28.00	28.65	**1620444.00**	
Medication Dispensing System Total:							**171873.52**
Medication Dispensing System - Install		Install	31	1.00	52.78	**1636.18**	

Medication Dispensing System - Monthly	☐	Monthly	494	7.00	49.23	**170237.34**	
Orientation and Mobility Services Total:							**10113.00**
Orientation and Mobility Services	☐	15 min	20	15.00	33.71	**10113.00**	
Peer Support Total:							**1267378.20**
Peer Support	☐	15 min	330	529.00	7.26	**1267378.20**	
Senior Care Options (SCO) Total:							**17429947.20**
Senior Care Options (SCO)	☑	PMPM	2920	9.00	663.24	**17429947.20**	
Supportive Day Program Total:							**33956.01**
Supportive Day Program	☐	15 min	33	37.00	27.81	**33956.01**	
Supportive Home Care Aide Total:							**14773066.96**
Supportive Home Care Aide	☐	15 min	694	3028.00	7.03	**14773066.96**	
Transitional Assistance Total:							**174.94**
Transitional Assistance	☐	Episode	2	1.00	87.47	**174.94**	
Transportation Total:							**476310.60**
Transportation - one-way trip	☐	One-Way Trip	900	12.00	38.97	**420876.00**	
Transportation - per mile	☐	Mile	260	103.00	2.07	**55434.60**	

GRAND TOTAL:	**262604273.16**
Total: Services included in capitation:	17429947.20
Total: Services not included in capitation:	245174325.96
Total Estimated Unduplicated Participants:	**19400**
Factor D (Divide total by number of participants):	**13536.30**
Services included in capitation:	898.45
Services not included in capitation:	12637.85
Average Length of Stay on the Waiver:	281

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia							

Coaching Total:							**12943.34**
Alzheimer's/Dementia Coaching	☐	Visit	74	1.00	174.91	**12943.34**	
Home Health Aide Total:							**86311847.16**
Home Health Aide	☐	15 min	3897	3366.00	6.58	**86311847.16**	
Homemaker Total:							**50396098.77**
Homemaker	☐	15 min	10573	753.00	6.33	**50396098.77**	
Personal Care Total:							**68288753.40**
Personal Care	☐	15 min	7097	1580.00	6.09	**68288753.40**	
Respite Total:							**143633.16**
Respite	☐	Per diem	46	11.00	283.86	**143633.16**	
Chore Total:							**1090634.04**
Chore	☐	15 min	1206	103.00	8.78	**1090634.04**	
Companion Total:							**10628358.85**
Companion	☐	15 min	2551	809.00	5.15	**10628358.85**	
Complex Care Training and Oversight (formerly Skilled Nursing) Total:							**1314436.32**
Complex Care Training and Oversight (formerly Skilled Nursing)	☐	Visit	2307	6.00	94.96	**1314436.32**	
Enhanced Technology/Cellular Personal Emergency Response System (PERS) Total:							**408776.67**
Cellular PERS - Install	☐	Install	327	1.00	41.01	**13410.27**	
Cellular PERS - Monthly	☐	Monthly	1320	9.00	33.28	**395366.40**	
Environmental Accessibility Adaptation Total:							**711487.52**
Environmental Accessibility Adaptation	☐	Item	1948	2.00	182.62	**711487.52**	
Evidence Based Education Programs Total:							**417592.08**
Evidence Based Education Programs	☐	Class	654	12.00	53.21	**417592.08**	
Goal Engagement Program Total:							**1743246.40**
Goal Engagement Program	☐	Episode	491	1.00	3550.40	**1743246.40**	
Grocery Shopping and Delivery Total:							**176641.92**
Grocery Shopping and Delivery	☐	Order	337	21.00	24.96	**176641.92**	
Home Based Wandering Response Systems Total:							**10564.80**

Home Based Wandering Response Systems - Install	☐	Install	10	1.00	41.01	**410.10**	
Home Based Wandering Response Systems - Monthly	☐	Monthly	30	9.00	37.61	**10154.70**	
Home Delivered Meals Total:							**9133256.30**
Home Delivered Meals	☐	Meal	7771	161.00	7.30	**9133256.30**	
Home Delivery of Pre-packaged Medication Total:							**9037.62**
Home Delivery of Pre-packaged Medication	☐	Monthly	46	9.00	21.83	**9037.62**	
Home Safety/Independent Evaluations (formerly Occupational Therapy) Total:							**5292.33**
Home Safety/Independent Evaluations (formerly Occupational Therapy)	☐	Visit	67	1.00	78.99	**5292.33**	
Laundry Total:							**1642914.00**
Laundry	☐	Order	2006	28.00	29.25	**1642914.00**	
Medication Dispensing System Total:							**174414.21**
Medication Dispensing System - Install	☐	Install	31	1.00	53.89	**1670.59**	
Medication Dispensing System - Monthly	☐	Monthly	491	7.00	50.26	**172743.62**	
Orientation and Mobility Services Total:							**15489.00**
Orientation and Mobility Services	☐	15 min	30	15.00	34.42	**15489.00**	
Peer Support Total:							**1924665.99**
Peer Support	☐	15 min	491	529.00	7.41	**1924665.99**	
Senior Care Options (SCO) Total:							**19746277.20**
Senior Care Options (SCO)	☑	PMPM	3240	9.00	677.17	**19746277.20**	
Supportive Day Program Total:							**34664.19**
Supportive Day Program	☐	15 min	33	37.00	28.39	**34664.19**	
Supportive Home Care Aide Total:							**14979576.56**
Supportive Home Care Aide	☐	15 min	689	3028.00	7.18	**14979576.56**	
Transitional Assistance Total:							**178.62**
Transitional Assistance	☐	Episode	2	1.00	89.31	**178.62**	
Transportation Total:							**482460.78**
Transportation - one-way trip	☐	One-Way Trip	893	12.00	39.79	**426389.64**	

Transportation - per mile	☐	Mile	258	103.00	2.11	**56071.14**	

GRAND TOTAL:	**269803241.23**
Total: Services included in capitation:	19746277.20
Total: Services not included in capitation:	250056964.03
Total Estimated Unduplicated Participants:	**19600**
Factor D (Divide total by number of participants):	**13765.47**
Services included in capitation:	1007.46
Services not included in capitation:	12758.01
Average Length of Stay on the Waiver:	281

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia Coaching Total:							**13036.34**
Alzheimer's/Dementia Coaching	☐	Visit	73	1.00	178.58	**13036.34**	
Home Health Aide Total:							**87311347.20**
Home Health Aide	☐	15 min	3860	3366.00	6.72	**87311347.20**	
Homemaker Total:							**50944651.74**
Homemaker	☐	15 min	10473	753.00	6.46	**50944651.74**	
Personal Care Total:							**69088028.00**
Personal Care	☐	Per diem	7030	1580.00	6.22	**69088028.00**	
Respite Total:							**143460.90**
Respite	☐	15 min	45	11.00	289.82	**143460.90**	
Chore Total:							**1101918.72**
Chore	☐	15 min	1194	103.00	8.96	**1101918.72**	
Companion Total:							**10748988.84**
Companion	☐	15 min	2526	809.00	5.26	**10748988.84**	
Complex Care Training and Oversight (formerly Skilled Nursing) Total:							**1329184.50**
Complex Care							

Training and Oversight (formerly Skilled Nursing)		Visit	2285	6.00	96.95	**1329184.50**	
Enhanced Technology/Cellular Personal Emergency Response System (PERS) Total:							**516333.96**
Cellular PERS - Install		Install	324	1.00	41.87	**13565.88**	
Cellular PERS - Monthly		Monthly	1644	9.00	33.98	**502768.08**	
Environmental Accessibility Adaptation Total:							**719735.60**
Environmental Accessibility Adaptation		Item	1930	2.00	186.46	**719735.60**	
Evidence Based Education Programs Total:							**633705.12**
Evidence Based Education Programs		Class	972	12.00	54.33	**633705.12**	
Goal Engagement Program Total:							**1761730.56**
Goal Engagement Program		Episode	486	1.00	3624.96	**1761730.56**	
Grocery Shopping and Delivery Total:							**178716.72**
Grocery Shopping and Delivery		Order	334	21.00	25.48	**178716.72**	
Home Based Wandering Response Systems Total:							**14242.70**
Home Based Wandering Response Systems - Install		Install	10	1.00	41.87	**418.70**	
Home Based Wandering Response Systems - Monthly		Monthly	40	9.00	38.40	**13824.00**	
Home Delivered Meals Total:							**9232166.65**
Home Delivered Meals		Meal	7697	161.00	7.45	**9232166.65**	
Home Delivery of Pre-packaged Medication Total:							**9027.45**
Home Delivery of Pre-packaged Medication		Monthly	45	9.00	22.29	**9027.45**	
Home Safety/Independent Evaluations (formerly Occupational Therapy) Total:							**5322.90**
Home Safety/Independent Evaluations (formerly Occupational Therapy)		Visit	66	1.00	80.65	**5322.90**	
Laundry Total:							**1661290.96**
Laundry		Order	1987	28.00	29.86	**1661290.96**	
Medication Dispensing System Total:							**176296.26**
Medication Dispensing System - Install		Install	31	1.00	55.02	**1705.62**	

Medication Dispensing System - Monthly	☐	Monthly	486	7.00	51.32	**174590.64**	
Orientation and Mobility Services Total:							**21084.00**
Orientation and Mobility Services	☐	15 min	40	15.00	35.14	**21084.00**	
Peer Support Total:							**1946201.58**
Peer Support	☐	15 min	486	529.00	7.57	**1946201.58**	
Senior Care Options (SCO) Total:							**22369923.45**
Senior Care Options (SCO)	☑	PMPM	3595	9.00	691.39	**22369923.45**	
Supportive Day Program Total:							**34324.16**
Supportive Day Program	☐	15 min	32	37.00	28.99	**34324.16**	
Supportive Home Care Aide Total:							**15137153.68**
Supportive Home Care Aide	☐	15 min	682	3028.00	7.33	**15137153.68**	
Transitional Assistance Total:							**182.38**
Transitional Assistance	☐	Episode	2	1.00	91.19	**182.38**	
Transportation Total:							**488181.80**
Transportation - one-way trip	☐	One-Way Trip	885	12.00	40.63	**431490.60**	
Transportation - per mile	☐	Mile	256	103.00	2.15	**56691.20**	

GRAND TOTAL:	**275586236.17**
Total: Services included in capitation:	22369923.45
Total: Services not included in capitation:	253216312.72
Total Estimated Unduplicated Participants:	**19800**
Factor D (Divide total by number of participants):	**13918.50**
Services included in capitation:	1129.79
Services not included in capitation:	12788.70
Average Length of Stay on the Waiver:	280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Alzheimer's/Dementia							

Coaching Total:							**13127.76**
Alzheimer's/Dementia Coaching	☐	Visit	72	1.00	182.33	**13127.76**	
Home Health Aide Total:							**88068158.64**
Home Health Aide	☐	15 min	3814	3366.00	6.86	**88068158.64**	
Homemaker Total:							**51427490.40**
Homemaker	☐	15 min	10348	753.00	6.60	**51427490.40**	
Personal Care Total:							**69689218.00**
Personal Care	☐	15 min	6946	1580.00	6.35	**69689218.00**	
Respite Total:							**146475.45**
Respite	☐	Per diem	45	11.00	295.91	**146475.45**	
Chore Total:							**1112091.00**
Chore	☐	15 min	1180	103.00	9.15	**1112091.00**	
Companion Total:							**10843447.68**
Companion	☐	15 min	2496	809.00	5.37	**10843447.68**	
Complex Care Training and Oversight (formerly Skilled Nursing) Total:							**1341116.52**
Complex Care Training and Oversight (formerly Skilled Nursing)	☐	Visit	2258	6.00	98.99	**1341116.52**	
Enhanced Technology/Cellular Personal Emergency Response System (PERS) Total:							**626860.44**
Cellular PERS - Install	☐	Install	320	1.00	42.75	**13680.00**	
Cellular PERS - Monthly	☐	Monthly	1964	9.00	34.69	**613180.44**	
Environmental Accessibility Adaptation Total:							**726109.32**
Environmental Accessibility Adaptation	☐	Item	1907	2.00	190.38	**726109.32**	
Evidence Based Education Programs Total:							**852684.84**
Evidence Based Education Programs	☐	Class	1281	12.00	55.47	**852684.84**	
Goal Engagement Program Total:							**1776518.40**
Goal Engagement Program	☐	Episode	480	1.00	3701.08	**1776518.40**	
Grocery Shopping and Delivery Total:							**180318.60**
Grocery Shopping and Delivery	☐	Order	330	21.00	26.02	**180318.60**	
Home Based Wandering Response Systems Total:							**18072.00**

Home Based Wandering Response Systems - Install	☐	Install	10	1.00	42.75	**427.50**	
Home Based Wandering Response Systems - Monthly	☐	Monthly	50	9.00	39.21	**17644.50**	
Home Delivered Meals Total:							**9317722.05**
Home Delivered Meals	☐	Meal	7605	161.00	7.61	**9317722.05**	
Home Delivery of Pre-packaged Medication Total:							**9217.80**
Home Delivery of Pre-packaged Medication	☐	Monthly	45	9.00	22.76	**9217.80**	
Home Safety/Independent Evaluations (formerly Occupational Therapy) Total:							**5434.44**
Home Safety/Independent Evaluations (formerly Occupational Therapy)	☐	Visit	66	1.00	82.34	**5434.44**	
Laundry Total:							**1675852.36**
Laundry	☐	Order	1963	28.00	30.49	**1675852.36**	
Medication Dispensing System Total:							**177749.40**
Medication Dispensing System - Install	☐	Install	30	1.00	56.18	**1685.40**	
Medication Dispensing System - Monthly	☐	Monthly	480	7.00	52.40	**176064.00**	
Orientation and Mobility Services Total:							**26910.00**
Orientation and Mobility Services	☐	15 min	50	15.00	35.88	**26910.00**	
Peer Support Total:							**1962801.60**
Peer Support	☐	15 min	480	529.00	7.73	**1962801.60**	
Senior Care Options (SCO) Total:							**25342874.91**
Senior Care Options (SCO)	☑	PMPM	3989	9.00	705.91	**25342874.91**	
Supportive Day Program Total:							**35046.40**
Supportive Day Program	☐	15 min	32	37.00	29.60	**35046.40**	
Supportive Home Care Aide Total:							**15265722.56**
Supportive Home Care Aide	☐	15 min	674	3028.00	7.48	**15265722.56**	
Transitional Assistance Total:							**186.20**
Transitional Assistance	☐	Episode	2	1.00	93.10	**186.20**	
Transportation Total:							**492372.04**
Transportation - one-way trip	☐	One-Way Trip	874	12.00	41.48	**435042.24**	

Transportation - per mile		Mile	253	103.00	2.20	**57329.80**	

GRAND TOTAL:	**281133578.81**
Total: Services included in capitation:	25342874.91
Total: Services not included in capitation:	255790703.90
Total Estimated Unduplicated Participants:	**20000**
Factor D (Divide total by number of participants):	**14056.68**
Services included in capitation:	1267.14
Services not included in capitation:	12789.54
Average Length of Stay on the Waiver:	280