COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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CONTRACTOR LEGAL NAME: Boston Medical Center Health Plan, Inc. **(and d/b/a):** WellSense Health Plan		**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS	
Legal Address: (W-9, W-4): 529 Main St., Ste. 500, Charlestown, MA, 02129		**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108	
Contract Manager: Nelie Lawless	**Phone:** 617-791-9346	**Billing Address (if different):**	
E-Mail: Nelie.Lawless@BMCHP-wellsense.org	**Fax:**	**Contract Manager:** Alejandro Garcia Davalos	**Phone:** 617-838-3344
Contractor Vendor Code: VC7000072388		**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov	**Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**		**MMARS Doc ID(s):** N/A **RFR/Procurement or Other ID Number:** BD-22-1039-EHS01-ASHWA-71410	

☒ **NEW CONTRACT**

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

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

☐ **CONTRACT AMENDMENT**

Enter **Current Contract End Date *Prior*** to Amendment: _____, 20_____.
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.)

MassHealth is contracting with Boston Medical Center Health Plan, Inc. for its Accountable Care Partnership Plan with Boston Children's Health Accountable Care Organization, LLC, and will hold them accountable for the overall health of, and cost and quality of care for, defined populations of Members.

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

☐ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.
☒ 2. may be incurred as of **January 1, 2023**, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.
☐ 3. were incurred as of _____, 20_____, a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **December 31, 2027,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

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

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:

X: DocuSigned by: _____. Date: 12/20/2022.
DA35C714BCEA4A7...
(Signature and Date Must Be Captured At Time of Signature)
Print Name: James Collins.
Print Title: CFO.

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: Amanda Cassel Kraft. Date: 12/21/2022.
Amanda Cassel Kraft (Dec 21, 2022 15:26 EST)
(Signature and Date Must Be Captured At Time of Signature)
Print Name: **Amanda Cassel Kraft**.
Print Title: **Assistant Secretary for MassHealth**.

ACCOUNTABLE CARE PARTNERSHIP PLAN CONTRACT

FOR THE

MASSHEALTH ACCOUNTABLE CARE ORGANIZATION PROGRAM

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

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

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

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

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

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

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APPENDICES

SECTION 1. DEFINITIONS OF TERMS

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

Abuse – actions or inactions by Providers (including the Contractor) and/or Members that are inconsistent with sound fiscal, business or medical practices, and that result in unnecessary cost to the MassHealth program, including, but not limited to practices that result in MassHealth reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care.

Accountable Care Organization Partner (ACO Partner) – the ACO entity the Contractor has an arrangement with for this Contract as described in **Section 2.3.A.2.** and as identified in **Appendix R**.

Accountable Care Organizations (ACOs) – Certain entities, contracted with EOHHS as accountable care organizations, that enter into population-based payment models with payers, wherein the entities are held financially accountable for the cost and quality of care for an attributed Member population. Accountable Care Partnership Plans and Primary Care ACOs are the two types of ACOs in MassHealth's ACO Program. Entities that enter into a Contract with EOHHS pursuant to the RFR are ACOs.

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

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

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

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

ACO-CP Flexible Services Partnership Model – a model through which a CP participates in an ACO's Flexible Services program(s).

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

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

Actuarial Standards Board, and have been approved by CMS. This includes capitation rates being based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 CFR 457.10.

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

Administrative Component – See **Section 4.2.B**.

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

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

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

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

- the failure to provide ACO Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.9.B**.;
- the denial or limited authorization of a requested service, including the determination that a requested service is not an ACO Covered Service;
- the reduction, suspension, or termination of a previous authorization by the Contractor for a service;
- the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:
    - failure to follow prior authorization procedures;
    - failure to follow referral rules;
    - failure to file a timely claim;
    - the failure to act within the timeframes in **Section 2.7.C.6**. for making authorization decisions; and
    - the failure to act within the timeframes in **Section 2.13.B.4**. for reviewing an Internal Appeal and issuing a decision.

- the involuntary transfer of an Enrollee to a different PCP pursuant to **Section 2.4.E.3.d**.

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

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

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

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

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

ASAM – the American Society for Addiction Medicine, a professional society in the field of addiction medicine that sets standards, guidelines, and performance measures for the delivery of addiction treatment which includes a continuum of five basic levels of care from Level 0.5 (early intervention) to Level 4.0 (medically managed intensive inpatient treatment). References to levels within the Contract with respect to Behavioral Health services are references to these ASAM levels.

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

BH – Behavioral Health. See Behavioral Health Services.

BH CP – Behavioral Health Community Partner.

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

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

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

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

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

Behavioral Health Supports for Individuals with Justice Involvement (BH-JI) – BH-JI supports involve a range of functions that assist MassHealth Members with justice involvement, including those members who are currently incarcerated or detained in a correctional facility, released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the 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 as well as community supports post-release. 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 as described in **Section 2.9.C.12**.

Behavioral Health Urgent Care – the delivery of same-day or next-day appointments for evaluation or assessment for new clients and urgent appointments for existing clients; psychopharmacology appointments and Medication Assisted Treatment (MAT) within a timeframe defined by EOHHS; all other treatment appointments within 14 calendar days; and extended availability outside of weekday hours between 9am and 5pm, as specified by EOHHS by certain Mental Health Centers (MHC), approved by the Contractor as Behavioral Health Urgent Care Providers, as specified by EOHHS.

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

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

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

Bureau of Special Investigations (BSI) – a bureau within the Office of the State Auditor that is charged with the responsibility of investigating Member fraud within the Commonwealth's public assistance

programs, principally those administered by the Department of Transitional Assistance (DTA), the EOHHS Office of Medicaid and the Department of Children and Families (DCF).

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

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

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

Care Management – the provision of person-centered, coordinated activities to support Enrollees' goals as described in **Section 2.6** of this Contract.

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

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

Care Team – a multidisciplinary team responsible for coordinating certain aspects of a member's care, as further described in **Section 2.6.C**.

Care Team Point of Contact – A member of a BH CP or LTSS CP Enrollee's care team responsible for ongoing communication with the care team, as described in **Section 2.6**. The Care Team Point of Contact may be the Enrollee's PCP or PCP Designee, or the Contractor's staff member that has face-to-face contact with the PCP or the care team.

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

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

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

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

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

Children in the Care or Custody of the Commonwealth – children who are Enrollees and who are in the care or protective custody of the Department of Children and Families (DCF), or in the custody of the Department of Youth Services (DYS).

Chronic Homelessness: a definition established by the U.S. Department of Housing and Urban Development (HUD) of a disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for 12 months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter, or safe haven) over a three-year period where the combined occasions must total at least 12 months (occasions must be separated by a break of at least seven nights; stays in institution of fewer than 90 days do not constitute a break). To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious and persistent mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness, or disability, including the co-occurrence of two or more of those conditions.

Claim – a Provider's bill for services, performed per Enrollee, by line item, including but not limited to services performed, units of service, and billing charges.

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

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

Clinical Advice and Support Line – a phone line that provides Enrollees with information to support access to and coordination of appropriate care, as described in **Section 2.5.G**.

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

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

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

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

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

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

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

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

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

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

Community Service Agency (CSA) – a community-based Behavioral Health provider organization whose function is to facilitate access to the continuum of Behavioral Health services by providing an organized pathway to care for children and families where the child is referred for Intensive Care Coordination. A

primary mechanism through which CSAs serve this function is as the provider of Intensive Care Coordination and Family Support and Training Services, which are a BH Covered Services.

Comprehensive Assessment – a person-centered assessment of an Enrollee's care needs, functional needs, accessibility needs, goals, and other characteristics, as described in **Section 2.5.B.4**

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

Contract – this contract executed between the Contractor and EOHHS pursuant to EOHHS's Request for Responses (RFR) for Accountable Care Organizations

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

Contract Operational Start Date – the date on which the Contractor starts to provide ACO Covered Services to Enrollees, which shall be April 1, 2023.

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

Contractor– any entity that enters into an agreement with EOHHS for the provision of services described in the Contract, as set forth in **Appendix R**.

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

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

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

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

Core Medical Component – See **Section 4.2.B**.

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

County Correctional Facility – Jails and Houses of Correction in Massachusetts, which hold individuals in a carceral setting.

CP Clinical Care Manager – an individual within a CP who is responsible for overseeing RN staff and/or supervisory staff who oversee the Care Coordinators, and final review and approval of the Enrollee's Comprehensive Assessment and Care Plan.

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

Credentialing Criteria – criteria establishing the qualifications of Network Providers. See **Section 2.9.H.** of this Contract.

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

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

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

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

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

DCF – the Massachusetts Department of Children and Families.

DDS – the Massachusetts Department of Developmental Services.

DHCD – the Massachusetts Department of Housing and Community Development.

DPH – the Massachusetts Department of Public Health.

DTA – the Massachusetts Department of Transitional Assistance.

DYS – the Massachusetts Department of Youth Services.

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

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

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

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

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

Designated Pediatric Expert – The Designated Pediatric Expert must be a licensed clinician, such as a Social Worker (LCSW/LICSW), a Registered Nurse (RN) or another licensed medical professional such as a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), or Physician's Assistant (PA) with pediatric expertise. The Designated Pediatric Expert experience shall include but not be limited to working directly with pediatric patients and their families, supporting children with Special Health Care Needs and their families, identifying and navigating supports for health-related social needs. The qualifications for the Designated Pediatric Expert shall be made available to EOHSS.

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

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

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

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

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

Drug Rebate (Medicaid Drug Rebate Program) – a program authorized by Section 1927 of the Social Security Act involving CMS, state Medicaid agencies, and approximately 600 participating drug

manufacturers that helps to offset the federal and state costs of most outpatient prescription drugs dispensed to Medicaid patients.

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

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

Early Intensive Behavioral Intervention (EIBI): provided to children under three years of age who have a diagnosis of autism spectrum disorder (ASD) and meet clinical eligibility criteria. Such services shall be provided only by DPH-approved, Early Intensive Behavioral Intervention Service Providers

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

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

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

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

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

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

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

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

- A physician,
- A practitioner described in section 1842(b)(18)(C) of the Act,
- A physical or occupational therapist or a qualified speech-language pathologist, or
- A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

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

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

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

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

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

Encounter Data – a dataset provided by the Contractor that records every service provided to an Enrollee. This dataset shall be developed in the format specified by EOHHS and shall be updated electronically according to protocols and timetables established by EOHHS in accordance with **Appendix E**.

Enrollee – a Member enrolled in the Contractor's Plan, either by choice, or assignment by EOHHS. A Member shall be considered an Enrollee beginning on the Effective Date of Enrollment in the Contractor's Plan, including retroactive enrollment periods. A Member shall not be considered an Enrollee during any period following the Effective Date of Disenrollment from the Contractor's Plan, including retroactive disenrollment periods.

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

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

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

Enrollee Information – information about an Accountable Care Partnership Plan for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.8.E**., and an Enrollee handbook that contains all of the information in **Section 2.4.B.2.f.**

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

- Have complex or chronic medical needs requiring specialized health care services, including persons with multiple chronic conditions, co-morbidities, and/or co-existing functional impairments, and including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities described below;
    - Cognitive Disability – a condition that leads to disturbances in brain functions, such as memory, orientation, awareness, perception, reasoning, and judgment. Many conditions can cause cognitive disabilities, including but not limited to Alzheimer's disease, bipolar disorder, Parkinson disease, traumatic injury, stroke, depression, alcoholism, and chronic fatigue syndrome.
    - Intellectual Disability – is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior that affect many everyday social and practical skills.
    - Mobility Disability - an impairment or condition that limits or makes difficult the major life activity of moving a person's body or a portion of his or her body. "Mobility disability" includes, but is not limited to, orthopedic and neuro-motor disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.
    - Psychiatric Disability – a mental disorder that is a health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Examples include, but are not limited to, depression, bipolar disorder, anxiety disorder, schizophrenia, and addiction.
    - Sensory Disability - any condition that substantially affects hearing, speech, or vision.
- Are children/adolescents who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally;
- Are at high risk for admission/readmission to a 24-hour level of care within the next six months;
- Are at high risk of institutionalization;

- Have been diagnosed with a Serious Emotional Disturbance, a Serious and Persistent Mental Illness, or a substance use disorder, or otherwise have significant BH needs;
- Are Chronically Homeless;
- Are at high risk of inpatient admission or Emergency Department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting; or
- Receive care from other state agency programs, including but not limited to programs through Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Children and Families (DCF), and Department of Youth Services (DYS).

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

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

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

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

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

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

Experimental Treatment – services for which there is insufficient authoritative evidence that such service is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

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

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

Family Resource Centers (FRCs) of Massachusetts – A statewide network that provides services to strengthen families and keep them connected to resources within their own community. There are FRCs in every county in the Commonwealth. The FRCs help families access housing and employment supports as well as health and behavioral health services. They also provide school supports, assistance with childcare and transportation, and provide equipment, clothing, food, and other assistance to families.

Fast Healthcare Interoperability Resources (FHIR) – FIHR is a next-generation interoperability standard created by the standards development organization Health Level 7 (HL7®). FHIR is designed to enable health data, including clinical and administrative data, to be quickly and efficiently exchanged.

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

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

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

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

FHIR-based APIs – HL7® FHIR® includes specifications for an API, based on established web standards and modern information exchange that has been extended to create a full interoperability solution for health care.

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

Flexible Services – certain services to address health-related social needs as described in **Section 2.23.B** and **Appendix M**.

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

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

Grievance – any expression of dissatisfaction by an Enrollee or an Enrollee's Appeal Representative about any action or inaction by the Contractor other than an Adverse Action. Possible subjects for

Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of the Contractor, or failure to respect the Enrollee's rights.

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

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

Health Equity – The opportunity for everyone to attain their full health potential. Regardless of their social position (e.g., socioeconomic status) or socially assigned circumstance (e.g., race, gender identity/gender expression, ethnicity, disability status, religion, sexual orientation, geography, disability, language etc.).

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

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

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

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

Health Related Social Needs (HRSN) – The immediate daily necessities that arise from the inequities caused by the social determinants of health, such as a lack of access to basic resources like stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection.

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

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

Homeless Management Information Systems (HMIS) – A federal requirement for agencies that receive funding for services/housing for people experiencing homelessness. Specifically, local homeless planning groups, known as continuums of care, are required to develop and implement a local HMIS to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness

HPC – the Massachusetts Health Policy Commission

Incarcerated – Individuals or members who are incarcerated includes (1) Individuals in County Correctional Facilities and Department of Corrections (DOC) facilities (including pre-arraignment individuals, pre-trial detainees, sentenced individuals, and civilly-committed individuals); and (2) Detained and committed youth in hardware-secure facilities in the Department of Youth Services (DYS) juvenile justice system.

Incentive Payment Arrangement – any payment mechanism under which the Contractor may receive additional funds, over and above the Capitation Rates paid, for meeting targets specified in the Contract and often referred to as incentives in the Contract. See **Section 4.6** and 42 CFR 438.6.

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

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

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

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

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

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

LTSS CP – Long-Term Services and Supports Community Partner.

Managed Care Organization (MCO) – any entity, contracted with EOHHS as an MCO, that provides, or arranges for the provision of, covered services under a capitated payment arrangement, that is licensed and accredited by the Massachusetts Division of Insurance as a Health Maintenance Organization (HMO), and is organized primarily for the purpose of providing health care services, that (a) meets advance directives requirements of 42 CFR Part 489, subpart I; (b) makes the services it provides to its Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Members within the area served by the entity; (c) meets the EOHHS's solvency standards; (d)

assures that Enrollees will not be liable for the Contractor's debts if the Contractor becomes insolvent; (e) is located in the United States; (f) is independent from EOHHS' Enrollment Broker, as identified by EOHHS; and (g) is not an excluded entity described in 42 CFR 438.808(b). MassHealth members enrolled in an MCO use the MCO's network of providers.

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

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

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

Massachusetts Health Information Highway (Mass HIway) – a health information exchange program within the Commonwealth of Massachusetts' Executive Office of Health and Human Services.

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

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

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

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

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

MassHealth Managed Care – the provision of Primary Care, Behavioral Health, and other services through an ACO, MCO, or the PCC Plan for all managed care eligible Members under age 65, in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000 et seq.

MassHealth Member (Member) – any individual determined by EOHHS to be eligible for MassHealth.

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

Material Subcontractor – any entity the Contractor (directly or through its ACO Partner) 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 ACO Covered Services or Flexible Services including, but not limited to, behavioral health, claims processing, Care Management, Utilization Management or pharmacy benefits, including specialty pharmacy providers. Contracts with Material Subcontractors shall be referred to as Material Subcontracts.

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

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

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

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

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

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

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

Network Management – refers to the activities, strategies, policies and procedures, and other tools used by the Contractor in the development, administration, and maintenance of the collective group of health care Providers under contract to deliver ACO Covered Services.

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

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

Non-ACO Covered Services – those services specified in **Appendix C, Exhibit 2** of the Contract which are coordinated by the Contractor, but are provided by EOHHS on an FFS basis.

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

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

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

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

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

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

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

Opioid Treatment Programs (OTP) – Substance Abuse and Mental Health Services Administration (SAMHSA)-certified programs, usually comprised of a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using approved medications, of individuals who are addicted to opioids in accordance with **105 CMR 164.300** and **42 CFR Part 8**.

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

- National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:
    - Wrong surgical or other invasive procedure performed on a patient;
    - Surgical or other invasive procedure performed on the wrong body part;
    - Surgical or other invasive procedure performed on the wrong patient;
    - For each of the above, the term "surgical or other invasive procedure" is defined in CMS Medicare guidance on NCDs.
- 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.

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

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

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

Performance Incentive Arrangement – a payment mechanism as further described in **Section 4** under which the Contractor may earn payments for meeting targets in the Contract. See 42 CFR 438.6(b).

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

Post-stabilization Care Services – ACO Covered Services, related to an Emergency Medical Condition, whether physical or mental, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or, when covered pursuant to 42 CFR 438.114(e), to improve or resolve the Enrollee's condition.

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

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

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

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

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

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

Primary Care Clinician (PCC) Plan – a managed care option administered by EOHHS through which enrolled MassHealth Members receive Primary Care and certain other medical services. See 130 CMR 450.118. MassHealth members enrolled in the PCC Plan receive behavioral health services through MassHealth's behavioral health vendor.

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

Primary Care Provider (PCP) – the individual Primary Care Provider or team selected by the Enrollee, or assigned to the Enrollee by the Contractor, to provide and coordinate all of the Enrollee's health care needs and to initiate and monitor referrals for specialty services when required. PCPs include nurse practitioners practicing in collaboration with a physician under Massachusetts General Laws Chapter 112, Section 80B and its implementing regulations or physicians who are board certified or eligible for certification in one of the following specialties: Family Practice, Internal Medicine, General Practice, Adolescent and Pediatric Medicine, or Obstetrics/Gynecology. PCPs for persons with disabilities, including but not limited to, persons with HIV/AIDS, may include practitioners who are board certified or eligible for certification in other relevant specialties.

Privacy and Security Rules – the standards for privacy of individually identifiable health information required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191

(HIPAA), and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended).

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

Provider – See Network Provider.

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

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

Provider Performance Incentive – any payment or other compensation granted to, or withheld from, a Provider as a result of engagement, or lack of engagement, in a targeted behavior, such as compliance with guidelines and other Quality Improvement initiatives, in accordance with **Section 5.1.H**. and **Section 2.14.D.** All Provider Performance Incentives must comply with the requirements of Physician Incentive Plans as described in **Section 5.1.H** of this Contract.

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

Provider Site Marketing – any activities occurring at or originating from a Provider site, whereby Contractor staff or designees, including physicians and office staff, personally present Contractor Marketing Materials or other Marketing Materials produced by the Provider site to Members that EOHHS can reasonably determine influence the Member to enroll in the Contractor's MassHealth Plan or to disenroll from the Contractor's MassHealth Plan into another MassHealth Plan. This shall include direct mail campaigns sent by the Provider site to its patients who are Members. With one exception, described in **Section 2.12.B.3**, Provider Site Marketing is prohibited.

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

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

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

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

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

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

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

Rate Year – See **Appendix D.**

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

Region – A geographic area used for the purpose of the development of Base Capitation Rates. See **Section 4**.

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

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

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

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

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

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

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

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

Serious Reportable Event (SRE) – an event that occurs on premises covered by a hospital's license that results in an adverse patient outcome, is clearly identifiable and measurable, usually or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital. An SRE is an event that is designated as such by the Department of Public Health (DPH) and identified by EOHHS.

Service Area – a geographic area, specified by EOHHS and as listed in **Appendix F** of the Contract, in which a Contractor has contracted with EOHHS to serve MassHealth Members.

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

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

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

State Fiscal Year – the twelve-month period commencing July 1 and ending June 30 and designated by the calendar year in which the fiscal year ends (e.g., State Fiscal Year 2023 ends June 30, 2023).

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

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

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

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

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

Total Cost of Care Benchmark (**TCOC Benchmark**) – the PCACO and PCC Plan total cost of care target used to compare a PCACO's and PCC Plan's expenditures during the Rate Year against when calculating shared savings or shared losses. The TCOC Benchmark is set by EOHHS prospectively. EOHHS may under certain circumstances make additional, retrospective adjustments to the TCOC Benchmark.

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

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

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

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

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

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

SECTION 2. CONTRACTOR RESPONSIBILITIES

Section 2.1 Compliance

A. General

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

B. Federal Managed Care Law

The Contractor shall comply with all applicable provisions of 42 U.S.C. § 1396u-2 et seq. and 42 CFR 438 et seq. at all times during the term of this Contract.

C. Conflict of Interest

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

D. Systems Interface

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

Section 2.2 Contract Transition/Contract Readiness

A. Contract Readiness Phase

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

1. Contract Readiness Applicability

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

b. The Contract Readiness Phase, and the readiness provisions in **Section 2.2.B**, shall also apply, as determined appropriate by EOHHS, upon the

implementation of changes in scope to this Contract and new programs or initiatives as described in **Sections 5.8 and 5.9** of this Contract, as further specified by EOHHS, including but not limited to in the event that additional populations become managed care eligible;

2. Contract Readiness Workplan

a. No later than five business days following the Contract Effective Date, or other date as specified by EOHHS, the Contractor shall submit to EOHHS, for its review and approval, a workplan which shall be used by EOHHS to monitor the Contractor's progress toward achieving Contract readiness, as detailed in **Section 2.2.B** below, in accordance with timelines specified by EOHHS. The workplan shall:

1) Address all of the items listed in **Section 2.2.B.2**, at a minimum, for each Service Area in which the Contractor has contracted with EOHHS to serve Enrollees.

2) List each task, the date by which it will be completed, how it will be completed, and the documentation that will be provided to EOHHS as evidence that the task has been completed.

b. EOHHS may, in its discretion, modify or reject any such workplan, in whole or in part The Contractor shall modify its workplan as specified by EOHHS and resubmit for approval.

B. Contract Readiness Review Requirements

1. Readiness Review Overview

a. EOHHS will conduct a readiness review of the Contractor to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

b. Readiness review shall be conducted prior to enrollment of Enrollees with the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS.

c. Readiness review shall include an on-site review as determined appropriate by EOHHS. At the request of EOHHS, the Contractor shall provide to EOHHS or its designee, access to all facilities, sites, and locations at which one or more services or functions required under this Contract occurs or is provided;

d. At the request of EOHHS, the Contractor shall provide to EOHHS or its designee, access to all information, materials, contracts, or documentation pertaining to the provision of any service or function required under this Contract within five

business days of receiving the request;

e. EOHHS reserves the right to conduct additional readiness reviews, as determined appropriate by EOHHS, upon the implementation of changes in scope to this Contract and new programs or initiatives as described in **Sections 5.8 and 5.9** of this Contract, as further specified by EOHHS, including but not limited to in the event that additional populations become managed care eligible.

2. Scope of Readiness Review

The scope of the Readiness Review shall include, but may not limited to:

a. An assessment of the Contractor's ability and capability to perform, at a minimum, its obligations under the Contract satisfactorily in the following areas set consistent with 42 CFR 438.66(d)(4) as determined appropriate by EOHHS:

1) Operational and Administration, specifically

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

b) Delegation and oversight of Contractor responsibilities, including but not limited to capabilities of Material Subcontractors in accordance with **Section 2.3.C**;

c) Enrollee and Provider communications;

d) Internal Grievance and Appeal policies and procedures, in accordance with **Section 2.13**;

e) Enrollee services and outreach, including capabilities (materials, processes and infrastructure, e.g., call center capabilities), in accordance with **Section 2.11**;

f) Provider Network management, including Provider Network composition and access, in accordance with **Section 2.8**;

g) Program integrity and compliance, including Fraud and Abuse and other program integrity requirements in accordance with **Section 2.3.D**;

2) Service Delivery

a) Case management, care coordination, and service planning in accordance with **Section 2.6**;

b) Quality improvement, including comprehensiveness of quality management/quality improvement strategies, in accordance with **Section 2.14**; and

c) Utilization Review, including comprehensiveness of Utilization Management strategies, in accordance with **Section 2.7.D**

3) Financial Management

a) Financial reporting and monitoring; and

b) Financial solvency, in accordance with **Section 2.16**;

4) Systems Management

a) Claims management; and

b) Encounter Data and enrollment information, as applicable, management, including but not limited to, at the request of EOHHS, a walk-through of any information systems, including but not limited to enrollment, claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with **Section 2.15**, including IT testing and security assurances.

b. A review of other items specified in the Contract, including but not limited to:

1) Marketing materials, in accordance with **Section 2.12**;

2) Content of Provider Contracts, including any Provider Performance Incentives and risk arrangements, in accordance with **Sections 2.8.B, 2.14.D and 5.1.H**;

3) Content of Material Subcontracts with Community Partners, in accordance with **Sections 2.6.F**; and

4) Primary care sub-capitation policies and procedures, in accordance with **Section 2.23**.

3. Completing Readiness Review

a. The Contractor shall demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet readiness review requirements in sufficient time prior to the Contract Operational Start Date. The Contractor shall provide EOHHS with a certification, in a form and format specified by EOHHS, demonstrating such readiness;

b. If EOHHS identifies any deficiency in the Contractor satisfying readiness review

requirements, the Contractor shall provide EOHHS, in a form and format specified by EOHHS, a remedy plan within five business days of being informed of such deficiency. EOHHS, may, in its discretion, modify or reject any such remedy plan, in whole or in part.

c. MassHealth Members shall not be enrolled into the Contractor's Plan unless and until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the readiness review, except as provided below.

1) EOHHS may, in its discretion, postpone the Contract Operational Start Date for any Contractor that does not satisfy all readiness review requirements.

2) Alternatively, EOHHS may, in its discretion, enroll MassHealth Enrollees into the Contractor's Plan as of the Contract Operational Start Date provided the Contractor and EOHHS agree on a corrective action plan to remedy any deficiencies EOHHS identifies pursuant to this Section.

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

Section 2.3 Administration and Contract Management

A. Organization, Staffing, and Key Personnel

1. Structure and Governance

The Contractor shall:

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

b. Be located within the United States;

c. Acquire and maintain Health Policy Commission (HPC) ACO certification or have an ACO Partner that maintains such certification:

d. Use best efforts to have a minimum of approximately twenty thousand (20,000) Enrollees, except if the Contractor has prior written approval from EOHHS to have fewer Enrollees;

e. At all times during the Contract Term, the Contractor or the ACO Partner shall

have, or the agreement between the Contractor and ACO Partner shall establish and maintain, a governance structure that includes, at a minimum:

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

2) A Governing Board.

    a) Such Governing Board shall:

        (i) Be at least seventy-five percent controlled by Providers or their designated representatives; and

        (ii) Include at least one MassHealth consumer or MassHealth consumer advocate as a voting member. Such consumer or consumer advocate shall not be included in either the numerator or the denominator in calculating the seventy-five percent control threshold requirement of **Section 2.3.A.e.2.i**;

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

    c) Nothing in section shall absolve the Contractor of any responsibility to EOHHS to perform the requirements of this Contract.

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

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

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

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

        (iii) Being involved with the development and updating of cultural and linguistic policies and procedures, including those related to Quality Improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English;

        (iv) Advising on the cultural appropriateness and member-

centeredness of necessary member or provider targeted services, programs, and trainings; Contractor marketing materials and campaigns; and Contractor partnerships;

(v) Providing input and advice on member experience survey results and other appropriate data and assessments;

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

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

(i) Considers cultural, linguistic, racial, disability, sexual orientation, and gender identities, among others; and

(ii) Includes representatives from parents or guardians of pediatric Enrollees

d) The Contractor shall ensure, or require that the ACO Partner ensure:

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

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

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

4) A Health Equity Committee as described in **Section 2.21.A**; and

5) A Quality Committee

2. ACO Partner

The Contractor shall have an ACO Partner. The Contractor shall:

a. At all times after the Contract Effective Date, have a written contract with its ACO Partner;

b. Provide executed contracts between the Contractor and ACO Partner as requested by EOHHS, as well as other materials requested by EOHHS related to the Contractor and ACO Partner's arrangement. The Contractor shall modify the contract between Contractor and the ACO Partner, and other related materials, as requested by EOHHS to ensure Contractor's compliance with this Contract;

c. Ensure its ACO Partner does not otherwise participate as part of the MassHealth ACO Program, including as an ACO Partner for another Accountable Care Partnership Plan or as a Primary Care ACO;

d. Ensure its ACO Partner obtains and, at all times after the Contract Operational Start Date, maintains a Risk Certificate for Risk-Bearing Provider Organizations (RBPO) or a Risk Certificate Waiver for RBPO, as defined by the Massachusetts Division of Insurance (DOI), and as further directed by EOHHS;

e. Ensure its ACO Partner otherwise complies with the requirements of this Contract; and

f. At a minimum, have functional integration, including developing processes for and demonstrating implementation of joint decision-making, with the ACO Partner across all the following domains, as determined and approved by EOHHS:

1) Financial accountability, as follows

a) The Contractor shall have a financial accountability arrangement with the ACO Partner whereby:

(i) The Contractor holds the ACO Partner financially accountable to some degree for the Contractor's performance under this Contract, with potential for the ACO Partner to receive partial gains or losses.

(ii) Under such arrangement, the ACO Partner's maximum annual potential for losses or gains based on Contractor's performance shall not be less than 15% of the Contractor's shared savings or shared losses;

b) The Contractor shall report to EOHHS, as directed by EOHHS and set forth in **Appendix A**, on this financial accountability arrangement including, but not limited to, details on how payments are calculated, amount and frequency of payments, and any other details EOHHS requests.

c) The Contractor shall ensure, as directed by EOHHS, that the ACO Partner's Chief Financial Officer or similar senior leader

engages in and certifies certain financial reports, relating to matters pertinent to the Contractor's and ACO Partner's arrangement;

2) Clinical integration, as follows:

The contract between Contractor and the ACO Partner shall obligate the ACO Partner to have responsibilities related to supporting Contractor's responsibilities as follows:

a) The Contractor and the ACO Partner shall work together, and clearly designate staff, to perform activities associated with this Contract such as but not limited to:

(i) Coordinating Enrollees' care as described in **Section 2.6**;

(ii) Developing Care Management protocols and procedures as described in **Section 2.6.E**;

(iii) Providing Care Needs Screenings to Enrollees as described in **Section 2.5.B.2**;

(iv) Providing Comprehensive Assessments and documented Care Plans to certain Enrollees as described in **Section 2.5.B.4**;

(v) Coordinating with Contractor's BH CPs and LTSS CPs as described in **Sections 2.6.F**;

(vi) Developing, implementing, and maintaining Contractor's Wellness Initiatives and Disease Management Programs as described in **Sections 2.5.C and 2.5.D**; and

(vii) Developing, implementing, and maintaining Contractor's Transitional Care Management program, including establishing appropriate protocols with Network hospitals, as described in **Section 2.5.F**;

(viii) Implementing the Primary Care Sub-Capitation Program, as described in **Section 2.23.A**.

b) The Contractor and its ACO Partner shall engage in regular meetings about high- and rising-risk Enrollees described in **Section 2.6.B** (e.g., joint clinical rounding);

c) The Contractor and its ACO Partner shall regularly meet and

engage on BH and pharmacy matters, including to review cost and quality data;

d) The Contractor shall engage the ACO Partner on complex requests for authorizations for ACO Covered Services consistent with **Section 2.7.C**.

3) Data integration, such that the Contractor shall share, to the extent permitted under applicable privacy and security laws, data with the ACO Partner to support ACO Partner activities under this Contract. Such data sharing shall occur in a timely manner, and shall include but is not limited to:

a) Reports and analytics on Contractor's performance on cost and Quality Measures under this Contract at an aggregate and primary care practice level;

b) A defined and coordinated process for obtaining, coordinating, and relaying information relevant to determining which Enrollees shall receive care coordination (as described in **Section 2.6**), including a method for intaking referrals and input from the ACO Partner and Network Providers

c) A defined and coordinated process for providing the ACO Partner and Network PCPs relevant claims and enrollment information about Enrollees, including but not limited to a list of Enrollees and periodic updates to such list, utilization reports, and admission, discharge, and transfer (ADT) information; and

d) A defined and coordinated process for the Contractor to collect relevant clinical information from Providers and provide such information to the ACO Partner

g. Establish defined, delegated responsibilities to the ACO Partner for activities associated with this Contract such as but not limited to:

1) Performing and facilitating appropriate follow-up based on Enrollees' identified care needs, as described in **Section 2.5.B**;

2) Providing Care Management staff;

3) Providing in-person Care Management activities in the settings described in **Section 2.6.E**; and

4) Convening care teams for certain Enrollees as described in **Section 2.6.E.6**;

h. As further specified by EOHHS, ensure the ACO Partner consistent with **Section 2.3.A.3.b**, appoints the following staff, with each position assuming the responsibilities described in **Section 2.3.A.3** below as they relate to the ACO Partner's work under the Contract.

1) Chief Medical Officer/Medical Director;

2) Pharmacy Director;

3) Behavioral Health Director;

4) Chief Financial Officer;

5) Chief Data Officer;

6) Key Contact;

7) Quality Key Contact

3. Key Personnel and Other Staff

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

a. The following roles shall be Key Personnel:

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

2) The Contractor's Chief Medical Officers/Medical Director, who shall be a clinician licensed to practice in Massachusetts and shall oversee Contractor's Care Delivery and Care Management activities, all clinical initiatives including quality improvement activities, including but not limited to clinical initiatives related to addressing the care needs of children, Utilization Management programs, and the review of all appeals decisions that involve the denial of or modification of a requested Covered Service;

3) The Contractor's Pharmacy Director who shall be responsible for the Contractor's activities related to pharmacy ACO Covered Services and shall attend Pharmacy Director meetings as described in this Contract and further directed by EOHHS;

4) The Contractor's Behavioral Health Director, who shall be responsible for Contractor's activities related to BH Services and related Care Delivery and Care Management activities, and for all BH-related

interaction with EOHHS;

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

6) The Contractor's Chief Data Officer, who shall have primary responsibility for ensuring management and compliance of all activities under **Section 2.15** and **Appendix E**;

7) The Contractor's Compliance Officer, who shall oversee Contractor's compliance activities including Contractor's Fraud and Abuse Prevention activities as described in this Contract and further specified by EOHHS;

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

   a) Ensuring that the Contractor and its Providers comply with federal and state laws and regulations pertaining to persons with disabilities. Such requirement shall include monitoring and ensuring that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Enrollees with physical or mental disabilities;

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

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

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

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

9) The Contractor's State Agency Liaison, who shall coordinate

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

a) A designated DCF liaison that works with DCF, including the DCF health and medical services team and the DCF medical social workers in the Contractor's Service Area(s). Such liaison shall:

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

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

(a) Working with DCF, including the DCF Ombudsman's Office, the DCF health and medical services team, and the DCF medical social workers, to assist EOHHS and DCF in the resolution of any problems or issues that may arise with an Enrollee;

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

(c) As requested by DCF, provide direction and assistance to the DCF health and medical services team and the DCF medical social workers on individual cases regarding ACO Covered Services and coordinating Non-ACO Covered Services;

(d) Assisting DCF and, if requested by DCF, foster parent(s), in obtaining appointments for ACO Covered Services;

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

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

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

b) A designated DYS liaison. Such liaison shall:

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

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

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

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

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

(vi) As requested by DYS, actively participate and provide advice and assistance to DYS regional directors and staff on individual cases regarding ACO Covered Services and coordinating Non-ACO Covered Services, including the planning and management of such services;

(vii) Assist DYS caseworkers in obtaining appointments for ACO Covered Services; and

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

c) A designated DMH liaison. Such liaison shall:

(i) Have at least two years of care management experience, at least one of which shall be working with

individuals with significant behavioral health needs;

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

(a) Working with DMH, including designated DMH case managers, as identified by DMH, and assisting EOHHS and DMH in resolving any problems or issues that may arise with a DMH-affiliated Enrollee;

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

(c) As requested by DMH, providing advice and assistance to DMH regional directors or case managers on individual cases regarding ACO Covered Services and coordinating Non-ACO covered services;

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

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

(f) Assisting DMH caseworkers with obtaining appointments for ACO Covered Services;

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

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

10) The Contractor's Ombudsman Liaison, who shall liaise with EOHHS'

Ombudsman to resolve issues raised by Enrollees;

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

12) The Contractor's Quality Key Contact, who shall oversee the Contractor's quality management and quality improvement activities under this Contract, including those described in **Section 2.14** and other quality activities as further specified by EOHHS;

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

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

15) Any other positions designated by EOHHS

b. The Contractor shall appoint Key Personnel as follows:

1) The Contractor shall appoint an individual to each of the roles listed in **Section 2.3.A.3**. The Contractor may appoint a single individual to more than one such role;

2) The Contractor shall have appointments to all Key Personnel roles no later than ninety (90) days prior to the Contract Operational Start Date, and shall notify EOHHS of such initial appointments;

3) Key Personnel shall, for the duration of the Contract, be employees of the Contractor (or the ACO Partner, as applicable for ACO Partner positions), shall not be subcontractors, and shall be assigned primarily to perform their job functions related to this Contract;

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

5) If EOHHS informs the Contractor that EOHHS is concerned that any Key Personnel are not performing the responsibilities described in this Contract, or are otherwise hindering Contractor's successful performance of the responsibilities of this Contract, the Contractor shall

investigate such concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS of such actions. If such actions fail to ensure such compliance to EOHHS' satisfaction, EOHHS may invoke intermediate sanction and corrective action provisions described in **Section 5.4**;

c. Administrative Staff

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

1) The Contractor's relationships with CPs and management of the CP contracts

2) Risk stratification;

3) Care Management;

4) Administration of the Flexible Services program, including managing relationships with Social Service Organizations, and

5) Population health initiatives and programs.

d. On an ad hoc basis when changes occur or as directed by EOHHS, the Contractor shall submit to EOHHS an overall organizational chart that includes senior and mid-level managers for the organization. The organizational chart shall include the organizational staffing for Behavioral Health Services and activities. If such Behavioral Health Services and activities are provided by a Material Subcontractor, the Contractor shall submit the organizational chart of the behavioral health Material Subcontractor which clearly demonstrates the relationship with the Material Subcontractor and the Contractor's oversight of the Material Subcontractor. For all organizational charts, the Contractor shall indicate any staff vacancies and provide a timeline for when such vacancies are anticipated to be filled.

B. Contract Management and Responsiveness to EOHHS

The Contractor shall ensure and demonstrate appropriate responsiveness to EOHHS requests related to this Contract, as follows:

1. Performance reviews

a. The Contractor shall attend regular performance review meetings as directed by

EOHHS;

b. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise, as requested by EOHHS, including but not limited to ACO Partner staff, attend such meetings;

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

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

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

b) Performance reporting information;

c) Quality Measure performance;

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

e) Drivers of financial, quality, or utilization performance, including but not limited to stratified utilization data by service categories, drug and procedure types, provider type, individual PCPs, and sites;

f) Measures showing impact of Network Provider payments varying from MassHealth fee schedule payments;

g) Financial projections and models showing impact of certain actions specified by EOHHS;

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

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

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

k) Performance of Material Subcontractors including but not

limited to any changes in or additions to Material Subcontractor relationships;

l) Utilization metrics;

m) Health Equity data completion and disparities reduction metrics as further specified by EOHHS; and

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

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

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

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

2. Timely response to EOHHS requests

a. The Contractor shall respond to any EOHHS requests for review, analysis, information, or other materials related to the Contractor's performance of this Contract by the deadlines specified by EOHHS. Such requests may include but are not limited to requests for:

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

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

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

4) Information regarding the Contractor's contracts and agreements with its ACO Partner and Network Providers, including on payment, risk-sharing, performance, and incentive arrangements;

5) Information regarding the payer revenue mix of the Contractor's

Network Providers;

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

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

8) Documentation and information related to the Contractor's program integrity activities as described in this Contract;

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

10) Cooperation and coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor in any Fraud detection and control activities, or other activities as requested by EOHHS; and

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

3. Performance Reporting

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

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

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

4. Ad hoc meetings

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

b. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present in person at such meetings, as requested by EOHHS,

including but not limited to Contractor's MassHealth Executive Director;

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

5. Participation in EOHHS Efforts

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

a. Efforts to promote the delivery of services in a Culturally and Linguistically Appropriate manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity

b. EOHHS activities related to Health Equity;

c. EOHHS activities related to Program Integrity;

d. Activities to verify or improve the accuracy, completeness, or usefulness of Contractor's data submissions to EOHHS, including but not limited to validation studies of such data;

e. Activities related to EOHHS' implementation and administration of its ACO Program efforts, including but not limited to efforts related to validation of provider identification mapping;

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

g. EOHHS efforts related to the development of EOHHS policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, including but not limited to The Roadmap to Behavioral Health Reform (or the BH Roadmap);

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

i. Training programs;

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

k. Workgroups and councils, including but not limited to workgroups related to

reporting or data submission specifications;

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

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

n. Any other activities related to this Contract; and

o. As directed by EOHHS, the Contractor shall comply with all applicable requirements resulting from EOHHS initiatives.

6. Policies and Procedures for Core Functions

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

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

b. Non-discrimination of MassHealth Enrollees;

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

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

e. Enrollee cooperation with those providing health care services;

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

g. Cost-sharing by Enrollees;

h. Advance directives;

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

j. Access and availability standards;

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

l. The provision of Culturally and Linguistically Appropriate Services;

m. Practice guidelines in quality measurement and improvement activities;

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

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

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

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

r. Retention of medical records;

s. Engagement and coordination with BH CPs and LTSS CPs, as described in **Section 2.6.E**; and

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

u. Care Management;

v. Public health emergencies

w. Risk stratification; and;

x. Claims processing.

C. Material Subcontractors

1. All Contractor requirements set forth in this Contract that are relevant to the arrangement between the Contractor and Material Subcontractor shall apply to Material Subcontractors as further specified by EOHHS.

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

3. All Material Subcontracts shall be prior approved by EOHHS. To obtain such approval, the Contractor shall make a request in writing and submit with that request a completed Material Subcontractor checklist report as set forth in **Appendix A**. using the template provided by EOHHS as may be modified by EOHHS from time-to-time.

a. For Material Subcontractors who are not pharmacy benefit managers or Behavioral Health subcontractors, the Contractor shall submit such report to EOHHS at least 60 calendar days prior to the date the Contractor expects to execute the Material Subcontract.

b. The Contractor shall submit such report for pharmacy benefit managers and behavioral health subcontractors 90 calendar days prior to the date the Contractor expects to execute the Material Subcontract.

c. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the Material Subcontractor checklist report. For Material Subcontractors who are pharmacy benefit managers, the Contractor shall provide a network adequacy report at EOHHS' request.

4. The Contractor's contract, agreement, or other arrangement with a Material Subcontractor shall:

a. Be a written agreement;

b. Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the Material Subcontractor is obligated to provide;

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

d. Require the Material Subcontractor to comply with all applicable Medicaid laws, regulations, and applicable subregulatory guidance, including but not limited to federally-required disclosure requirements set forth in this Contract;

e. Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the written agreement with the Material Subcontractor requires the Material Subcontractor to agree as follows. See also **Section 5.5**.

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

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

f. Stipulate, or the Contractor shall make best efforts to stipulate, that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the Material

Subcontractor is based.

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

6. Upon notifying any Material Subcontractor, or being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall notify EOHHS in writing no later than the same day as such notification, and shall otherwise support any necessary member transition or related activities as described in **Section 2.4.F** and elsewhere in this Contract.

7. In accordance with **Appendix A**, the Contractor shall regularly submit to EOHHS a report containing a list of all Material Subcontractors. Such report shall also indicate whether any of its Material Subcontractors are a business enterprise (for-profit) or non-profit organization certified by the Commonwealth's Supplier Diversity Office. The Contractor shall submit ad hoc reports, as frequently as necessary or as directed by EOHHS, with any changes to the report.

8. The Contractor shall remain fully responsible for complying with and meeting all of the terms and requirements of the Contract as well as complying with all applicable state and federal laws, regulations, and guidance, regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

9. 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 Enrollees and MassHealth shall disclose such contracts upon request

D. 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 A**, 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 A**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

4. Overpayments

a. Reporting Overpayments to EOHHS

1) The Contractor shall report overpayments to EOHHS using the following reports as specified in this section and **Appendix A**:

a) Notification of Provider Overpayments Report;

b) Fraud and Abuse Notification Report;

c) Summary of Provider Overpayments Report; and

d) Self-Reported Disclosures Report.

2) In accordance with **Appendix A**, the Contractor shall submit to EOHHS the Notification of Provider Overpayments Report and Fraud and Abuse Notification Report no later than five business days after the identification of the overpayment.

3) In accordance with **Appendix A**, 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.F**.

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 A**.

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 A**.

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.F**. 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.F**.

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 A** 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 2.9.H**, 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 **Section 2.9.H.6.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 2.3.D.5.b** 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 2.3.D.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 2.3.D.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) The amount of the finders' fee performance incentive, as determined by EOHHS, shall be as set forth in **Section 4.6**.

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 A** and all other Contract requirements, when it receives information about an Enrollee's circumstances that may affect their MassHealth eligibility, including but not limited to a change in the Enrollee's residence and the death of the Enrollee;

d. Report no later than five business days to EOHHS, in accordance with **Appendix**

A and all other Contract requirements, when it receives information about a Provider's circumstances that may affect its ability to participate in the Contractor's network or in MassHealth, including but not limited to the termination of the Provider's contract with the Contractor;

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 A**: 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 A** 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**

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

m. In accordance with **Appendix A**, have the CEO or CFO certify in writing to EOHHS

that after a diligent inquiry, to the best of their knowledge and belief, the Contractor is in compliance with this Contract as it relates to program integrity requirements and has not been made aware of any instances of Fraud and Abuse other than those that have been reported by the Contractor in writing to EOHHS;

7. Screening Employees and Subcontractors

In addition to the requirements set forth in **Section 2.9.H**, 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 2.9.H**.

E. 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.

F. 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 2.4 Enrollment and Education Activities

A. Eligibility Verification

The Contractor shall:

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

2. Instruct and assist the Contractor's Providers in the process and need for verifying an Enrollee's MassHealth eligibility and enrollment prior to providing any service at each point of service, through EOHHS's Eligibility Verification System (EVS); provided, however, the Contractor and its Providers shall not require such verification prior to providing Emergency Services.

B. Enrollment

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

2. The Contractor shall:

   a. On each business day, obtain from EOHHS, via the HIPAA 834 Enrollment File, and process information pertaining to all enrollments in the Contractor's Plan including the Effective Date of Enrollment;

   b. Accept for enrollment all Members, as described in **Section 4.1** of the Contract, referred by EOHHS in the order in which they are referred without restriction, except that the Contractor shall not accept for enrollment any individual who is currently enrolled with the Contractor through its commercial plan or a Qualified Health Plan offered through the Exchange and shall notify EOHHS of such third party liability in accordance with **Section 2.20**;

   c. Identify all Enrollees in the HIPAA 834 Enrollment Files for whom more than one MassHealth identification number has been assigned. The Contractor shall take all steps necessary to account for any Enrollees for whom more than one MassHealth identification numbers has been assigned, including but not limited to reporting on such Enrollees to EOHHS and merging multiple MassHealth identification numbers in their records, as further specified by EOHHS.

   d. Accept for enrollment in the Contractor's Plan, all Members identified by EOHHS at any time, without regard to income status, physical or mental condition (such as cognitive, intellectual, mobility, psychiatric, or sensory disabilities as further defined by EOHHS), sex, gender identity, sexual orientation, religion, creed,

race, color, physical or mental disability, national origin, ancestry, status as a Member, pre-existing conditions, expected health status, or need for health care services;

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

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

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

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

a) The name of the Contractor;

b) The Enrollee's name;

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

d) The Enrollee's MassHealth identification number;

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

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

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

g. Provide new Enrollees with Enrollee Information that meets the requirements of **Sections 2.11.C** and **D** including a Provider directory that meets the requirements of **Section 2.8.E** and an Enrollee handbook based on a model provided by EOHHS, as further directed by EOHHS, which contains the Enrollee Information specified below. Such Enrollee Information shall be provided either prior to or during the Enrollee orientation required under **Section 2.4.E.6.** The Contractor shall submit such Enrollee Information to be reviewed and approved

by EOHHS at least 60 days prior to publication. Such Enrollee Information shall be written in a manner, format and language that is easily understood at a reading level of 6.0 and below. The Enrollee Information shall be made available in Prevalent Languages and in Alternative Formats free-of-charge, including American Sign Language video clips. The Enrollee Information, shall include, but not be limited to, a description of the following:

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

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

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

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

5) Information about Flexible Services

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

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

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

9) The role of the PCP, the process for selecting and changing the Enrollee's PCP, and the policies on referrals for specialty care and for

other benefits not furnished by the Enrollee's PCP;

10) How to obtain information about Network Providers;

11) The extent to which, and how, after-hours and Emergency Services and 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 Community Behavioral Health Centers and how to access them;

    f) Services for Urgent Care provided through the Contractor's Network and how to access them;

    g) How to access and use the Behavioral Health Help Line , including how the Contractor's Clinical Advice and Support line will interface with the Behavioral Health Help Line;

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

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

12) Enrollee cost sharing;

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

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

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

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

translated materials;

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

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

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

20) Information on the availability of and access to Ombudsman services, including contact information for the Ombudsman, in accordance with **Section 2.13.A.8**;

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

    a) The right to file Grievances and Internal Appeals;

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

    c) The availability of assistance in the filing process;

    d) The method for exploring alternative services to the service that was requested and denied;

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

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

    g) The right to obtain a BOH hearing;

    h) The method for obtaining a BOH hearing;

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

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

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

23) Information on the access standards specified in **Section 2.10.B**;

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

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

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

27) The information specified in **Section 5.1.J.2** related to any service the Contractor does not because of moral or religious grounds.

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

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

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

1) Provide Enrollees with written notice of any significant changes in ACO Covered Services or Enrollee cost sharing, at least 30 days prior to the intended effective date of the change, or at least 60-day notice for a narrowed Pharmacy Network (i.e., less than "any willing provider") Provider. Such notice shall be reviewed and approved by EOHHS prior to distribution to Enrollees. The Contractor shall make best efforts to provide EOHHS with draft materials for review 60 days prior to the effective date of such change, or 90 days for significant changes to a narrowed pharmacy network;

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

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

a) A termination or non-renewal of a hospital, community health center or community mental health center contract, chain pharmacy, or other primary care Provider site, within the Contractor's network, in which case the Contractor shall provide notice of such termination or non-renewal to all Enrollees in the terminated Provider's Service Area and in all bordering Service Areas;

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

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

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

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

1) in addition to written notification, ensure that care is transitioned to another Provider in a timely manner to minimize any disruptions to treatment.

2) make accommodations to ensure such Enrollees may see their current provider for Medically Necessary ACO Covered Services until such transition can occur;

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

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

2) Information on physician incentive plans; and

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

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

o. The Contractor shall provide written notice of closure of a Network PCP, no later than 30 days prior to the practice closure effective date, to each Enrollee who received their Primary Care from the closing Network PCP. Such written notice shall describe how the Enrollee's continuing need for services shall be met. Notices to Enrollees of Network PCP closure notices must be approved by MassHealth.

C. Notification of Birth and Coverage of Newborns

The Contractor shall:

1. Provide ACO Covered Services, and all other services required to be provided to Enrollees under this Contract, to all newborn Enrollees in accordance with this Contract, including but not limited to **Section 2.7**. During the first 30 days of the newborn Enrollee's enrollment with the Contractor:

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

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

   c. The Contractor shall comply with all continuity of care requirements set forth in **Section 2.4.F** for newborn Enrollees.

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

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

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

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

D. Disenrollment

1. The Contractor shall:

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

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

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

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

2. The Contractor's Request for Enrollee Disenrollment

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

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

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

3) missed appointments by the Enrollee;

4) the Enrollee's diminished mental capacity, or

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

b. As further specified by EOHHS and in accordance with 130 CMR 508.003(D), the

Contractor may submit a written request to EOHHS to disenroll an Enrollee as follows:

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

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

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

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

            (a) Meet the access requirements specified in **Section 2.10.B** for the relevant provider type; and

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

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

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

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

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

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

E. PCP Selection, Assignment, Transfers and Responsibilities

1. PCP Selection

The Contractor shall:

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

b. Make its best efforts to assist and encourage each Enrollee to select a PCP within the Contractor's network. Such best efforts shall include, but not be limited to, providing interpreter services where necessary to assist the Enrollee in choosing a PCP, making efforts to contact those Enrollees who have not contacted the Contractor and, in the case of children in the care or custody of DCF or youth affiliated with DYS (either detained or committed), making efforts to contact the child's state caseworker through the EOHHS-appointed DCF or DYS liaison (see **Section 2.7.F.4**); and

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

2. PCP Assignment

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

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

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

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

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

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

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

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

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

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

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

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

d. The Contractor shall routinely and promptly inform PCPs of newly assigned

Enrollees and shall require PCPs to make best efforts to schedule an initial appointment with new Enrollees.

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

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

3. PCP Transfers

The Contractor shall:

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

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

c. Annually report to EOHHS on the results of the monitoring efforts described in **Section 2.4.E.3.b** above and **Section 2.8.E.8**, and the actions taken by the Contractor.

d. In regard to involuntary changes in PCPs:

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

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

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

c) missed appointments by the Enrollee;

d) the Enrollee's diminished mental capacity, or

e) the Enrollee's uncooperative or disruptive behavior resulting from their special needs (except when the Enrollee's continued

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

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

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

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

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

4) The Enrollee's new PCP to which the Contractor transfers the Enrollee shall be within the access and availability requirements set forth in **Section 2.10**; and

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

4. The Contractor shall maintain and monitor, on an ongoing basis, the completeness and accuracy of Enrollee/PCP and Enrollee/Network Primary Care Practice PID/SL designations. The Contractor shall:

a. Regularly report to EOHHS on the Contractor's Enrollee/PCP designations, as further specified by EOHHS, ensuring such information is accurate and up-to-date, as set forth in **Appendix A**, in a format and at a frequency to be specified by EOHHS.

a. Maintain accurate Enrollee/PCP and Enrollee/Network Primary Care Practice PID/SL designations, and regularly report such designations to EOHHS in accordance with **Appendix A**

b. As further specified by EOHHS, regularly audit Enrollee/PCP and Enrollee/Network Primary Care Practice PID/SL designations to identify Enrollees with no Network Primary Care Practice PID/SL designation or an incorrect Network Primary Care Practice PID/SL designation;

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

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

e. As further specified by EOHHS, engage with EOHHS on efforts to improve the accuracy of Enrollee/PCP and Enrollee/Network Primary Care Practice PID/SL designations

5. PCP Coordination with Behavioral Health Providers

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

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

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

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

d. Communicate, coordinate, and share information with entities involved in the Enrollee's care, Care Team, and care coordination, including BH CPs and ACO Care Management.

6. Enrollee Outreach, Orientation, and Education

The Contractor shall:

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

1) How Accountable Care Partnership Plans operate, including the role of

the PCP;

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

3) ACO Covered Services, limitations, and any Non-Medical Programs and Services offered by the Contractor;

4) The value of screening and preventive care;

5) How to obtain services, including:

   a) Emergency Services for physical and behavioral health;

   b) Accessing OB/GYN and specialty care;

   c) Behavioral Health Services;

   d) Disease Management programs;

   e) Care Management;

   f) Early Intervention Services;

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

   h) Smoking cessation services; and

   i) Wellness programs.

6) How to request or self-refer to supports provided by the Contractor, including:

   a) The Community Partners program

   b) Flexible Services

   c) ACO Care Management

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

   1) Implement innovative Enrollee education strategies for wellness care

and immunizations, as well as general health promotion and prevention, and behavioral health rehabilitation and recovery;

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

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

4) Provide condition and disease-specific information and educational materials to Enrollees, including information on its Care Management and Disease Management programs described in **Section 2.6**. Condition and disease specific information shall be oriented to various groups within the MassHealth Managed Care eligible population, including but not limited to:

   a) Enrollees with Special Health Care Needs;

   b) Enrollees experiencing homelessness;

   c) Limited English-speaking Enrollees;

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

   e) Adults who are seriously and persistently mentally ill;

   f) Children with Serious Emotional Disturbance;

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

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

   i) Enrollees, including but not limited to pregnant Enrollees, with substance use disorders inclusive of opioid use disorder and alcohol use disorder; and

   j) Adults with Co-Occurring Disorders;

5) Submit all proposed health promotion and wellness information, activities, and material to EOHHS for approval prior to distribution. The Contractor shall submit such information, activities, and material to EOHHS for approval at least 30 days prior to distribution;

c. Member Education and Related Enrollment Materials

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

a) Changes, including additions and deletions, to the Contractor's Provider Network from the Contractor's most recently printed Provider directory (or directories), described in **Section 2.8.E**;

b) Changes in the Contractor's Non-Medical Programs and Services offered to Enrollees, including but not limited to, fitness and educational programs in accordance with **Section 2.7.A.9** and **10**;

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

d) Changes in the Contractor's orientation and educational materials in compliance with **Section 2.4.E.6**; Changes requested in EOHHS's enrollment materials as a result of the changes described in paragraphs a-d above; and

e) Changes to the Network in accordance with **Section 2.4.B.j.3**

f) Any other significant change that impacts Enrollees.

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

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

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

process specified by EOHHS in consultation with the Contractor.

f. Transition Plan for Enrollees with Special Health Care Needs

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

1) Medical record documentation;

2) Completion of a Care Needs Screening;

3) Evaluation for Care Management;

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

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

6) Historical utilization data.

F. Continuity of Care for New Enrollees

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

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

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

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

1) Are pregnant;

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

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

4) Are receiving ongoing services such as dialysis, home health,

chemotherapy and /or radiation therapy;

5) Are children in the care or custody of DCF, and youth affiliated with DYS (either detained or committed);

6) Are hospitalized; or

7) Are receiving treatment for behavioral health or substance use; or

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

1) Scheduled surgeries;

2) Out-of-area specialty services;

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

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

5) Nursing home admission;

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

a. Identifying and communicating with Enrollees for whom continuity of care is required in accordance with this Section, and those Enrollees' providers (including but not limited to Network Providers);

b. Facilitating continuity of care so that new Enrollees may continue to see their current providers (including but not limited to Network Providers) for Medically Necessary ACO Covered Services for at least 90 days from the Contract Operational Start Date, or otherwise 30 days after the Effective Date of Enrollment except where specified below, including but not limited to:

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

2) For medical services

a) Ensuring that, for at least 90 days from the Contract Operational Start Date, or otherwise 30 days after the Effective Date of

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

b) Ensuring that, for at least 90 days from the Contract Operational Start Date, or otherwise 30 days after the Effective Date of Enrollment, new Enrollees with any of the following may have continued access. The Contractor shall ensure such continuity by providing new authorization or extending existing authorization, if necessary, without regard to Medical Necessity criteria, for at least the required 90-day or 30-day period:

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

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

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

3) For Behavioral Health Services

a) Ensuring that, for at least 90 days from the Contract Operational Start Date or 90 days after the Effective Date of Enrollment, whichever is longer, new Enrollees receiving outpatient Behavioral Health or substance use disorder care, including but not limited to Enrollees with upcoming appointments, ongoing treatments or services, or prior authorizations, may continue to seek and receive such care from providers (including non-Network) with whom they have an existing relationship for such care;

b) Ensuring that, for at least 90 days from the Contract Operational Start Date or 90 days after the Effective Date of Enrollment, whichever is longer, Enrollees actively receiving ABA Services for autism spectrum disorder or Early Intensive Behavioral Intervention services, may continue to receive such services.

The Contractor shall develop related protocols that include at a minimum the use of single-case agreements, full acceptance and implementation of existing prior authorizations for ABA Services, and individual transition plans.

4) Otherwise making accommodations for:

a) Upcoming appointments;

b) Ongoing treatments or services;

c) Pre-existing prescriptions;

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

e) Other medically necessary services.

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

d. Honoring all prior authorizations and prior approvals for services for the duration of such prior authorizations and prior approvals or, if the Contractor chooses to modify or terminate a prior authorization and prior approval, then the Contractor shall treat such modification or termination as an Adverse Action and follow the appeal rights policy and procedures, including notification to the Enrollee and the Enrollee's provider in question;

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

f. Ensuring that all Enrollees, including new Enrollees, may access Emergency Services at any emergency room, including from out-of-Network Providers, and that such Services are provided at no cost to the Enrollee, as described in **Section 2.10**;

g. For Enrollees who have an existing prescription, providing any prescribed refills of such prescription, unless Contractor has a prior authorization policy as described in **Section 2.6.B.3.h** and such policy requires a prior authorization for such prescription. If Contractor requires such prior authorization, Contractor shall, at a minimum, provide a 72-hour supply of such medication as described in **Section 2.6.B.3.h**;

h. For pregnant Enrollees, the following:

1) The Enrollee may choose to remain with their current provider of obstetrical and gynecological services, even if such provider is not in the

Contractor's Provider Network;

2) The Contractor is required to cover all Medically Necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six weeks of delivery, even if the provider of such services is not in the Contractor's Provider Network; and

3) However, if a pregnant Enrollee would like to select a new Provider of obstetrician and gynecological services within the Contractor's Provider Network, such Enrollee may do so;

i. For Enrollees affiliated with other state agencies, coordination and consultation with such agencies as described in **Section 2.7.F.2**;

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

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

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

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

a) Provider Fraud investigations;

b) Complaints from Enrollees;

c) Grievances from Providers and Enrollees;

d) Quality Management Plan; and

e) Quality Improvement project records;

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

1) Outreach to New Enrollees within two business days of such New

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

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

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

l. Include policies and procedures ensuring that the Contractor collaborates with and supports EOHHS in working with such Enrollees and their providers throughout and after the 90-day continuity of care period. Such collaboration and support shall include, but not be limited to, participating in Enrollee outreach, and identifying specific issues and working with EOHHS to resolve those issues.

4. Shall, for new Enrollees enrolled pursuant to **Section 2.9.A.1.q**:

a. Include all requirements in **Section 2.4.F.1-4** for a period of 90 days following the Enrollee's enrollment in the Contractor's plan;

b. For such Enrollees that have not transitioned to the Contractor's Network Providers at the conclusion of such 90-day continuity of care period, include policies and procedures to ensure best efforts for providing uninterrupted care beyond the 90-day period. Such efforts shall include, but shall not be limited to, honoring authorizations from the Enrollee's previous plan until the Contractor issues new authorizations for Medically Necessary services; paying out-of-network providers for services until such Enrollees have been transitioned to a Network Provider; and other measures as further specified by EOHHS;

c. Include policies and procedures to ensure that the Contractor operates efficient provider credentialing processes to add Enrollees' providers to the Contractor's Provider Network, in accordance with all other applicable Contract requirements; and

5. Shall include designating a specific contact person to respond to requests and concerns related to continuity of care, including from EOHHS, state agencies, CPs, other MassHealth Accountable Care Partnership Plans, and MassHealth PCACOs. The Contractor shall provide EOHHS with such individual's name, telephone number, and email address, and shall ensure such individual is available to EOHHS during business hours and at other times specified by EOHHS; and

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

7. Shall ensure that new Enrollees who were previously enrolled in a CP are transitioned to a CP with which the Contractor is sub-contracted, as appropriate, and meets the other criteria described in **Section 2.5.D**, as appropriate by no later than 30 days after the Effective Date of Enrollment;

Section 2.5 Care Delivery

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

A. General Care Delivery Requirements

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

1. Ensure that all Enrollees may access:

   a. Primary Care or Urgent Care during extended hours;

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

   c. Same-day appointments for certain services;

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

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

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

necessary and appropriate;

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

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

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

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

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

    a. Intensive Care Coordination;

    b. Family Support and Training Services;

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

    d. Therapeutic Mentoring Services;

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

    f. Youth Mobile Crisis Intervention Services;

7. Ensure that all Enrollees have access to emergency Behavioral Health Services, including immediate and unrestricted access to YMCI/AMCI services in the community and BH evaluation at emergency departments, 24 hours a day, seven days a week;

8. Follow up with an Enrollee within 24 hours of when the Enrollee accesses emergency Behavioral Health services, including Adult and Youth Mobile Crisis Intervention services;

9. In addition to contracting with all necessary Providers and Community Partners, establish affiliations with organizations, including community-based organizations and Social Services Organizations, as necessary to fulfil the requirements of this Section;

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

1. General Requirements

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

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

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

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

c. The Contractor shall report on Care Needs Screenings, Comprehensive Assessments, Health Related Social Needs Screenings, and Care Plans in a form and format as specified by EOHHS, in accordance with **Appendix A**. The Contractor shall also report on the Health-Related Social Needs Screening in a form and format as specified by EOHHS, in accordance with **Appendix Q**.

d. In addition to the Care Needs Screening, Health-Related Social Needs Screening, and Comprehensive Assessment set forth in this section, the Contractor shall employ other means to evaluate Enrollees' care needs, including but not limited to regular analysis of available claims, Encounter Data, and clinical data on Enrollees' diagnoses and patterns of care;

2. Care Needs Screening

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

a. Use a survey-based instrument;

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

c. Be conducted with the consent of the Enrollee;

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

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

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

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

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

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

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

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

    1) Unmet needs

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

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

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

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

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

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

    1) Unmet needs;

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

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

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

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

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

7) Risk for institutionalization; and

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

m. Evaluate each Enrollee's health-related social needs, as described in **Section 2.5.B.3**, provided, however that a Comprehensive Assessment or HRSN Screening in accordance with all Contract requirements may satisfy this requirement as further specified by EOHHS;

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

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

3. Health Related Social Needs Screening

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

b. The HRSN screening may occur as a unique screening, as part of the Care Needs Screening, as part of the Comprehensive Assessment, or through or in combination with any other tool deemed appropriate by the Contractor so long as the HRSN screening conducted fulfills the requirements of this section.

c. Health Related Social Needs screenings shall:

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

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

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

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

a) Housing insecurity;

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

c) Economic stress, including lack of access to utilities, including heating and internet;

d) Lack of access to transportation; and

e) Experience of violence

5) In addition to the domains set forth above, the Contractor shall screen Enrollees for at least one of the following domains, as appropriate:

a) For Enrollees up to the age of 21, needs in school or early childhood education-related services and supports;

b) For Enrollees between the age of 21 and 45, needs for employment supports;

c) For Enrollees 45 years and older, social isolation.

d. When the Contractor identifies a HRSN for an Enrollee, whether through the HRSN screening or any other Encounter, the Contractor shall:

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

a) Housing supports

b) Nutrition supports

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

d) Transportation services;

e) Support for Enrollees who have experienced violence;

f) Education supports and services for pediatric Enrollees,

including early childhood education-related supports;

g) Employment assistance; and

h) Support for social isolation;

2) If the Enrollee would like to receive services, provide care coordination for the Enrollee and provide appropriate referrals and follow-up to help the Enrollee address the HRSN in accordance with **Section 2.6.A.4**;

3) Ensure that Providers include relevant ICD-10 codes (such as "Z codes" included in categories Z55-65 and Z75) on any claims the Enrollee's Providers submit for the Enrollee related to the Encounter where the HRSN is identified. Such codes shall be used as supplemental diagnosis codes and shall not be used as the admitting or principal diagnosis codes.

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

5) Provide a Flexible Services screening and consider referring the Enrollee for Flexible Services as described in **Section 2.23.B**, as appropriate and as further specified by EOHHS.

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

4. Comprehensive Assessments

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

1) Enrollees with Special Health Care Needs;

2) High- or rising-risk Enrollees enrolled in enhanced care coordination as described in **Section 2.6.C**;

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

4) Provided, however, that unless clinically appropriate, the Contractor shall not conduct a new Comprehensive Assessment if an Enrollee has had a Comprehensive Assessment within the last calendar year that

includes all domains and considerations described in **Section 2.5.B.4.b**.

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

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

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

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

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

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

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

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

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

b) Health conditions;

c) Medications;

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

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

Instrumental Activities of Daily Living (IADLs);

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

g) Current and past mental health and substance use;

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

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

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

k) Risk factors for abuse or neglect;

l) HRSNs as described in **Section 2.5.B.3**, provided, however that a Care Needs Screening or HRSN Screening in accordance with all Contract requirements may satisfy this requirement, as further specified by EOHHS.

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

n) Other domains and considerations identified by EOHHS;

c. For Enrollees receiving care coordination services through Intensive Care Coordination or through MassHealth CARES for Kids as described in **Appendix C**, the assessment the Enrollee receives through Intensive Care Coordination or MassHealth CARES for Kids shall be considered the Comprehensive Assessment for the Enrollee. The Contractor shall ensure such assessments through Intensive Care Coordination and MassHealth CARES for Kids meet the requirements of this section and are documented in the Enrollee's medical record.

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

e. The Contractor shall update Comprehensive Assessments as follows:

1) At least annually;

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

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

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

1) Communicated to the Enrollee;

2) Documented in the Enrollee's medical record.

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

5. Care Plans

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

1) Enrollees with Special Health Care Needs;

2) High or rising risk Enrollees enrolled in enhanced care coordination as described in **Section 2.6.C**;

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

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

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

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

3) Care Plans shall be unique to each Enrollee;

4) Care Plans shall be in writing;

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

6) Care Plans shall be Enrollee-centered and developed under the direction of the Enrollee (or the Enrollee's authorized representative, if

applicable). Enrollees shall be provided with any necessary assistance and accommodations to prepare for, fully participate in, and to the extent preferred, direct the care planning process;

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

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

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

   c) Documenting the Enrollee's verbal approval of the Care Plan in the Enrollee's medical record, including a description of the accommodation need that does not permit the Enrollee to sign the Care Plan. In the absence of an accommodation need, the Contractor shall document the reason a signature was not obtainable and shall obtain a signature from the Enrollee within three (3) months of the verbal approval

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

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

10) Care Plans shall inform an Enrollee of the availability of and access to Ombudsman services in accordance with **Section 2.13.A.8**.

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

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

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

1) A cover sheet, as further specified by EOHHS, that includes contact information for the Enrollee; the Enrollee's care coordinator(s); the Enrollee's PCP or PCP Designee; additional care team members; and, for pediatric Enrollees, the Enrollee's school or early childhood supports, and any state agency supports, if applicable.

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

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

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

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

6) Identification of barriers to meeting goals;

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

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

9) Back-up or contingency plan; and

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

f. Care Plans shall be updated as follows:

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

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

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

a) Determining the Enrollee's progress toward goals;

b) Reassessing the Enrollee's health status;

c) Reassessing the Enrollee's goals;

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

e) Documenting recommendations for follow-up; and

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

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

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

g. For Enrollees receiving care coordination services through Intensive Care Coordination or through MassHealth CARES for Kids as described in **Appendix C**, the Care Plan the Enrollee receives through Intensive Care Coordination or MassHealth CARES for Kids shall be considered the Care Plan for the Enrollee. The Contractor shall ensure such plans through Intensive Care Coordination and MassHealth CARES for Kids meet the requirements of this section and are documented in the Enrollee's medical record.

6. Appropriate Follow Up

The Contractor shall ensure that Enrollees receive Medically Necessary ACO Covered Services and appropriate follow-up care based on their needs identified through any of the above assessments or screenings, including but not limited to as part of care coordination as further described in **Section 2.6**.

C. Wellness Initiatives

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

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

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

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

    c. Childbirth education and infant care classes;

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

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

    f. Early detection of mental health issues in children;

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

    h. Chronic disease self-management;

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

    j. Coping with losses resulting from disability or aging;

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

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

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

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

D. Disease Management

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

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

2. The Contractor shall utilize information resulting from its risk stratification processes described in **Section 2.6.B** to inform the development of Disease Management programs. Such programs shall include activities such as, but not limited to:

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

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

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

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

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

E. Emergency Departments

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

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

   a. Autism Spectrum Disorder (ASD);

   b. Intellectual or Developmental Disabilities (IDD);

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

   d. Co-morbid medical conditions; and

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

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

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

4. The Contractor shall take initiatives to help minimize Enrollees waiting in emergency departments, including but not limited to proactively identifying Enrollees who are at risk of hospitalization for behavioral health needs as part of the Care Needs Screening described in **Section 2.5.B.2**.

F. Transitional Care Management and Discharge Planning

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

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

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

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

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

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

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

2) Medication reconciliation;

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

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

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

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

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

g. Take into account the requirements for Network Provider contracts with hospitals as described in **Section 2.7.C.5**.

2. The Contractor shall, as further directed by EOHHS, including but not limited to in Managed Care Entity Bulletins, implement policies and procedures that ensure timely, appropriate, and comprehensive Discharge Planning for Enrollees experiencing homelessness or Enrollees at risk of homelessness. Such policies and procedures shall be consistent with federal and state privacy laws and regulations and shall:

a. Be incorporated into the Contractor's protocols for Transitional Care Management with all Network Hospitals;

b. Ensure that Discharge Planning activities for such Enrollees occur at the time of admission;

c. Ensure that Discharge Planning activities include the following as further specified by EOHHS:

1) The hospital must contact the Contractor at the time of admission in order to collaborate in identifying resources to assist with the Enrollee's housing situation;

2) At the time of admission, and as part of its general Discharge Planning processes, the hospital must assess each admitted Enrollee's current housing situation;

3) The hospital must invite and encourage participation in Discharge Planning, as appropriate, by the Enrollee, the Enrollee's family, providers, Community Partner, care coordinators, shelter staff, and any other supports identified by the Enrollee.

4) For any Enrollee who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or the Massachusetts Rehabilitation Commission (MRC), the hospital must invite and encourage designated staff from each such agency to participate in such Enrollee's discharge planning activities.

5) For any Enrollee that is not a client of DMH, DDS, or MRC, the hospital must determine whether the Enrollee may be eligible to receive services from some or all of those agencies and offer to assist in submitting an application to DMH, DDS, or MRC, as appropriate.

6) The hospital must determine whether the Enrollee has any substance use disorder, as further specified by EOHHS.

d. Ensure that Discharge Planning activities include the following assessment of options for discharge as further specified by EOHHS:

1) The hospital must ensure that discharge planning staff are aware of and utilize available community resources to assist with Discharge Planning.

2) For any Enrollee with skilled care needs, who needs assistance with activities of daily living, or whose behavioral health condition would impact the health and safety of individuals residing in the shelter, the hospital must make all reasonable efforts to prevent discharges to emergency shelters. For such Enrollees, the hospital must seek placement in more appropriate settings, such as DMH community-based programs or nursing facilities.

3) For any Enrollee who was experiencing homelessness prior to admission and is expected to remain in the hospital for fewer than 14 days, the hospital must contact the appropriate emergency shelter to discuss the Enrollee's housing options following discharge, as further specified by EOHHS.

4) For any Enrollee for whom discharge to an emergency shelter or specific placement cannot be secured, the hospital must provide additional supports and track discharges of such Enrollees as further specified by EOHHS.

e. Ensure that the hospital documents all Discharge Planning activities in the Enrollee's medical record as further specified by EOHHS.

f. For the purposes of this **Section 2.5.F**:

1) Enrollees experiencing homelessness shall be any Enrollee who lacks a fixed, regular, and adequate nighttime residence and who:

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

b) is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals; or

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

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

G. Clinical Advice and Support Line

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

1. General

The Contractor's Clinical Advice and Support Line shall:

a. Be easily accessible to Enrollees.

b. Have a dedicated toll-free telephone number;

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

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

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

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

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

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

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

c. Protocols to facilitate coordination of Enrollee care as follows:

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

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

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

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

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

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

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

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

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

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

Section 2.6 Coordinating Care for Enrollees

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

A. Baseline Care Coordination

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

    a. Assigning Enrollees to a Primary Care Provider and ensuring such Provider delivers services in accordance with the requirements described in **Section 2.8.C.1**;

    b. In accordance with **Section 2.5.B**, ensuring Enrollees are screened for physical health, Behavioral Health, and LTSS needs, and Health-Related Social Needs;

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

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

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

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

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

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

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

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

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

    l. Sharing information about identification and assessment of needs conducted by the Contractor with appropriate treating providers or other members of the

Enrollee's Care Team;

m. For Enrollees with identified Behavioral Health needs, ensuring that appropriate Behavioral Health Clinical Assessments and treatment planning are performed as described in **Section 2.9.D**;

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

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

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

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

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

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

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

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

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

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

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

d. Establish and maintain at least one relationship with a Provider or Social Services Organization to assist Enrollees in obtaining WIC and SNAP in each of the Contractor's Service Areas;

e. Utilize its Community Resource Database, as described in **Section 2.15.E.7**, to identify supports; and

f. Consider referral to the Flexible Services Program, as set forth in **Section 2.23.B**

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

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

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

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

B. Risk Stratification

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

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

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

b. Incorporate the results of any screenings or assessments, including Care Needs Screenings, Health-Related Social Needs Screenings, and Comprehensive Assessments as set forth in **Section 2.5.B** and the Flexible Services Screening as set forth in **Section 2.23.B.2.B**.

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

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

3. The Contractor shall evaluate and update its predictive modeling for bias, including evaluation of the data inputs to the modeling, twice per year, at a minimum.

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

5. The Contractor shall evaluate such high- and rising-risk Enrollees to determine their appropriateness for enhanced care coordination as set forth in **Section 2.6.C**.

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

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

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

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

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

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

5) Enrollees with unmet LTSS needs;

6) Enrollees with Special Health Care Needs;

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

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

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

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

a) Any history of complex or severe BH diagnosis;

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

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

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

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

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

c. The Contractor shall determine a perinatal Enrollee's appropriateness for an enhanced care coordination program based on criteria set forth in **Section 2.6.B.5.b** during pregnancy and within six weeks following the end of pregnancy.

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

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

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

1) Non-Emergent

2) Emergent/Primary Care Treatable

3) Emergent- ED Care Needed – Preventable/Avoidable

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

C. Enhanced Care Coordination

The Contractor shall provide enhanced care coordination supports as follows:

1. Of the Enrollees the Contractor identifies as appropriate for enhanced care coordination as described in **Section 2.6.B**, the Contractor shall enroll Enrollees in an ACO Care Management program as set forth in **Section 2.6.D** or in a CP as set forth in **Section 2.6.E**. The Contractor may enroll Enrollees in both an ACO Care Management program and a CP as appropriate and as further specified by EOHHS.

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

        1) For BH CP, Enrollees ages 18-64 with predominant behavioral health need(s), such as serious and persistent mental illness (SPMI), serious emotional disturbance (SED), substance use disorder (SUD), or co-occurring SPMI/SUD.

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

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

2. The Contractor shall provide Enrollees determined appropriate for enhanced care coordination programs in accordance with **Section 2.6.B** with the enhanced care coordination supports described in this Section, in addition to all baseline care coordination supports set forth in **Section 2.6.A.**

    a. The Contractor shall:

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

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

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

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

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

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

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

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

d. For perinatal Enrollees identified as high-risk, as described in **Section 2.6.B.5.b.10**, and assigned to an enhanced care coordination program, the Contractor shall ensure such Enrollees receive enhanced care coordination during pregnancy and up to 12 months postpartum.

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

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

1) Calling the Enrollee;

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

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

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

5) Utilizing electronic communication to contact the Enrollee.

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

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

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

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

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

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

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

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

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

4) Enrollee's guardian or caregivers;

5) State agency or other case managers;

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

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

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

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

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

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

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

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

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

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

3) Providing intensive support for transitions of care as described in **Section 2.6.C.5**; and

4) Coordinating supports to address HRSNs, including:

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

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

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

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

5. In addition to having a Transitional Care Management program as well as meeting the requirements for Discharge Planning for Enrollees experiencing homelessness or Enrollees at risk of homelessness as set forth in **Section 2.5.F.2**, the Contractor shall support transitions of care as follows for Enrollees enrolled in an enhanced care coordination program:

a. For purposes of this section, transitions of care shall include inpatient discharge or transition, including but not limited to discharge from an acute inpatient hospital, nursing facility, chronic disease and rehabilitation, psychiatric inpatient hospital, substance abuse hospital, collectively referred to as "inpatient discharge" for the purposes of this **Section 2.6.C**, twenty-four (24) hour diversionary setting discharge, Emergency Department (ED) discharge, or any other change in treatment setting;

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

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

d. Within seven (7) calendar days following an Enrollee's emergency department (ED) discharge, the Contractor shall ensure the Care Coordinator follows up with the Enrollee face-to-face or via telehealth (e.g., telephone or videoconference, or as further specified by EOHHS), and at a minimum:

    1) Updates the Enrollee's Care Plan; and

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

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

    1) Conducts a visit with the Enrollee. For CP enrollees, this visit must be face-to-face;

    2) Updates the Enrollee's Care Plan, if applicable; and

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

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

    1) Reviews the updated Care Plan, if applicable;

    2) Conducts a Medication Review in accordance with **Section 2.6.C.6**; and

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

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

h. The Contractor shall ensure that the Care Coordinator assists Enrollees in accessing supports to which they are referred following a transition of care.

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

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

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

1) During the development of the Enrollee's Comprehensive Assessment and Care Plan;

2) Following a transition of care, within 7 calendar days unless further specified by EOHHS;

3) When the Enrollee reports a medication change; and

4) At least once annually thereafter.

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

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

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

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

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

4) Supporting the Enrollee in understanding the regimen and developing

strategies to maintain adherence to the medication regimen.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

section.

12. The Contractor shall perform the enhanced care coordination services described in this Section for Enrollees enrolled in an enhanced care coordination program as well as in a CSP program, in accordance with **Section 2.9.C.13.**

D. ACO Care Management

The Contractor shall:

1. Develop, implement, and maintain policies and procedures for providing ACO Care Management that meets the requirements described in **Sections 2.6.C-D** and shall provide those policies and procedures to EOHHS as further specified by EOHHS.

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

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

    a. Enrollees in both ACO Care Management and a CP count toward the minimum enrollment requirements described in **Section 2.6.D** and **Section 2.6.E**, for both programs, up to a maximum of 1% of the Contractor's total number of Enrollees.

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

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

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

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

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

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

    b. The Enrollee's home;

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

    d. Foster homes, group homes, residential schools, and other residential

placements locations;

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

f. 24-hour level of care facilities for Behavioral Health or Substance Use Disorder treatment.

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

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

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

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

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

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

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

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

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

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

The Contractor shall maintain contracts with Community Partners as follows:

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

a. The Contractor shall modify their CP subcontracts or subcontract with different

CPs upon request from EOHHS, including if a CP is determined to be no longer qualified by EOHHS.

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

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

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

2. The Contractor shall delegate the enhanced care coordination requirements described in **Section 2.6.C** for CP Enrollees to its CPs. The Contractor shall ensure its CPs meet the requirements of **Sections 2.6.C** and **2.6.E**, and **Appendix P**.

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

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

      1) Fidelity to the CP supports care model;

      2) Critical incident reporting;

      3) Grievances;

      4) Record keeping;

      5) Performance on quality measures; and

      6) Qualifying Activities (QAs).

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

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

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

   a. The Contractor shall enroll approximately 3% of its Enrollees in BH CPs (if applicable

pursuant to **Section 2.6.E.1.c**), or other number as further specified by EOHHS.

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

c. Enrollees in both ACO Care Management and a CP count toward the minimum enrollment requirements described in **Section 2.6.D** and **Section 2.6.E**, for both programs, up to a maximum of 1% of the Contractor's total number of Enrollees.

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

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

   a. With which the Contractor has a subcontract;

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

   c. That have confirmed capacity to accept the assignment.

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

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

      2) Sharing processing statuses for CP enrollees with CPs;

      3) Responding to CP inquiries about Enrollee processing status;

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

      5) Communicating resolution of enrollment issues to the CPs.

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

      1) When the Contractor, in consultation with the Enrollee and the Enrollee's CP, determines that the Enrollee has Graduated from the CP;

      2) When the Enrollee is unreachable after multiple outreach efforts, as determined by the Enrollee's CP;

      3) When the Enrollee has declined to participate in the CP program;

      4) When the Enrollee moves out of the geographic area(s) served by the

CP;

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

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

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

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

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

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

d. Other forms of coordination as appropriate.

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

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

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

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

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

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

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

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

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

a. The Contractor shall pay its CPs a panel-based payment, as further specified by EOHHS. This panel-based payment shall be at least the amount specified by EOHHS and account for a homelessness add-on as further specified by EOHHS. The applicable cost of the panel-based payment to CPs shall be reflected in the Administrative Component of the Base Capitation Rate, as further specified in **Section 4.2.**

b. The Contractor shall make annual quality performance-based payments to CPs as further specified by EOHHS.

c. For each payment above,

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

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

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

10. Data, reporting, and information exchange

a. The Contractor shall accept and utilize Electronic Data Interchange, HIPAA-compliant XL12 files from EOHHS, including the 834 daily and monthly audit files, and other files as specified by EOHHS, for the purposes of managing the Contractor's roster of CP Enrollees and for program management.

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

1) CP Enrollee contact information and PCP assignment;

2) CP Enrollee screening and assessment results;

3) CP Enrollee Care Plans;

4) CP Enrollee outreach status;

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

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

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

12. The Contractor shall designate appropriate administrative staff to satisfy the requirements of this **Section 2.6.E** and **Appendix P**, including at a minimum:

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

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

13. The Contractor shall:

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

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

Section 2.7 Covered Services

A. Covered Services and Other Benefits

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

1. Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary ACO Covered Services listed in **Appendix C**, in accordance with the requirements of this

Contract, and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under MassHealth fee-for-service;

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

    a. Prevent, diagnose, and treat disease, conditions, or disorders that result in health impairments;

    b. Achieve age-appropriate growth and development; and

    c. Attain, maintain, or regain functional capacity;

3. Not arbitrarily deny or reduce the amount, duration, or scope of a required ACO Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee;

4. Not deny authorization for an ACO Covered Service demonstrated to be Medically Necessary by a health care professional who has the clinical expertise in treating the Enrollee's medical condition or in performing the procedure or providing treatment, whether or not there is a Non-ACO Covered Service that might also meet the Enrollee's medical needs. Failure to provide Medically Necessary ACO Covered Services may result in intermediate sanctions pursuant to **Section 5.4**. of the Contract;

5. The Contractor may place appropriate limits on an ACO Covered Service on the basis of Medical Necessity, or for the purpose of utilization control, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines shall, at a minimum, be:

    a. Developed with input from practicing physicians in the Contractor's Service Area(s);

    b. Developed in accordance with standards adopted by national accreditation organizations;

    c. Developed in accordance with the definition of Medical Necessity in **Section 1** of this Contract and therefore no more restrictive than MassHealth Medical Necessity guidelines, QTLs and NQTLs;

    d. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

    e. Evidence-based, if practicable; and

    f. Applied in a manner that considers the individual health care needs of the Enrollee, including but not limited to the ongoing need for services of Enrollees with ongoing or chronic conditions;

6. Submit changes to its Medical Necessity guidelines, program specifications and services components for all ACO Covered Services to EOHHS no less than 60 days prior to any change, or another timeframe specified by EOHHS;

7. Coordinate the provision of all Non-ACO Covered Services listed in **Appendix C** in accordance with the requirements of this Contract. The Contractor shall inform Enrollees and Providers of:

    a. The availability of such services; and

    b. How to access such services through EOHHS's prior authorization process, where applicable;

8. Not be responsible for providing to Enrollees or coordinating any Excluded Services as described in **Appendix C**;

9. Offer to MassHealth Enrollees any additional Non-Medical Programs and Services available to a majority of the Contractor's commercial population on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon, in writing, by EOHHS and the Contractor, such as health club discounts, diet workshops, and health seminars. The Contractor is not permitted to submit the cost of Non-Medical Programs and Services in the report specified by EOHHS and found in **Appendix A** as an administrative, medical, or other expense;

10. Offer and provide to all Enrollees any and all Non-Medical Programs and Services specific to Enrollees for which the Contractor has received EOHHS approval;

11. For items or services provided under this Contract, the Contractor shall not cover such services outside the U.S and its territories and shall not provide any payments for such items or services to any entity or financial institution located outside the U.S.; and

12. The Contractor shall ensure that justice-involved Enrollees have access to medically necessary ACO Covered Services, including Behavioral Health Services, and ACO Care Management and care coordination as appropriate, as otherwise provided in this Contract;

13. The Contractor shall:

    a. Not impose on an Enrollee an annual dollar limit or an aggregate lifetime dollar limit on Behavioral Health Services; and

    b. Not impose on an Enrollee any quantitative treatment limitation, as defined in 42 C.F.R. 438.900, on Behavioral Health Services.

14. The Contractor shall not avoid costs of providing ACO Covered Services by referring Enrollees to publicly supported health care resources.

15. The Contractor shall make best efforts to maximize vaccinations of their Enrollees in accordance with the Department of Public Health guidelines.

B. Prescription Drug Management Program

The Contractor shall maintain a comprehensive prescription drug management program as follows:

1. Management and Support

The Contractor shall:

a. Dedicate a clinical pharmacist to oversee the program and shall provide additional pharmacy staffing as necessary to support the provisions of this Contract;

b. Participate in EOHHS Pharmacy Directors' Workgroup meetings and other standing or ad hoc meetings, task forces, or workgroups as necessary to support this Contract; and

c. Establish and maintain a call center to answer questions and provide support to pharmacy Providers and to prescribers.

d. If the Contractor uses a pharmacy benefit manager (PBM) to assist with the Contractor's prescription drug management program:

1) The Contractor shall follow all requirements with respect to Material Subcontractors set forth in this Contract, including but not limited to those set forth in **Section 2.3**; and

2) The Contractor shall ensure its contract with its PBM utilizes a pass-through contract model, consistent with applicable state law, where the PBM is only permitted to charge administrative fees for services it provides under the PBM contract.

2. Drug Coverage

The Contractor shall:

a. As described in **Appendix C**, cover all prescription drugs, Non-Drug Pharmacy Products, and over-the-counter drugs uniformly with how EOHHS covers such drugs and products for MassHealth fee-for-service Members as set forth in the MassHealth Drug List, and any updates thereto in the timeframe specified by EOHHS, including but not limited to the drugs and products themselves and any utilization management and authorization requirements for such drugs and products;

b. Operate and maintain a state-of-the-art National Council for Prescription Drug

Programs (NCPDP)-compliant, on-line pharmacy claims processing system. Such system shall allow for:

1) Financial, eligibility, and clinical editing of claims;

2) Messaging to pharmacies;

3) Pharmacy "lock-in" procedures consistent with MassHealth's controlled substance management program described at 130 CMR 406.442 using criteria equivalent to MassHealth criteria for enrollment listed on the MassHealth Drug List;

4) Downtime and recovery processes;

5) Electronic prescribing;

6) Electronic prior authorization

7) Claims from 340B entities as directed by EOHHS including but not limited to capturing 340B indicators and being able to process NCPDP standard transactions B1 (claim billing), B2 (claim reversal), and B3 (claim rebill).

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

9) As further directed by EOHHS, implementing the NCPDP Standard for transferring prior authorization information when an Enrollee disenrolls from the Contractor's plan and receiving prior authorization information for new Enrollees.

10) As directed by EOHHS, the Contractor shall implement 90-day supply requirements for drugs, including but not limited to covering some or all 90-day supplies for drugs, consistent with MassHealth fee-for-service requirements.

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

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

3. Clinical Management

The Contractor shall:

a. Have appropriate processes in place to clinically manage all prescription drugs, over-the-counter drugs, and Non-Drug Pharmacy Products consistent with **Section 2.7.B.2.a** and the MassHealth Drug List, unless otherwise specified by EOHHS.

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

c. Conduct Drug Utilization Review processes consistent with the requirements of 42 USC 1396r-8 and 42 CFR 45, including but not limited to:

1) At frequencies specified by EOHHS, reporting to EOHHS on Drug Utilization Review (DUR) activities in a form and format specified by EOHHS and in accordance with **Appendix A**.

2) Participating in EOHHS' MassHealth DUR advisory board.

3) Participating in clinical meetings to discuss MassHealth Drug List management.

d. At EOHHS' direction, synchronize the management of particular therapeutic areas with MassHealth's management of those therapeutic areas, including at a minimum, controlled substances and behavioral health medications in children. As determined appropriate by EOHHS, the Contractor shall also synchronize related programs and policies such as the Controlled Substance Management Program or lock-in criteria and operations.

e. Routinely report to EOHHS, in a form and format and frequency specified by EOHHS, prior authorization criteria, utilization and other metrics in therapeutic areas.

f. Promote the use of generic drugs and as identified by EOHHS, Preferred Drugs, and Non-Drug Pharmacy Products;

g. Conduct educational interventions or other outreach to prescribers to support drug list management objectives;

h. Maintain a prior authorization or other review process to determine Medical Necessity for prescription and over-the-counter drugs as set forth below and consistent with **Section 2.7.C**.

1) For any process that requires the Contractor's approval prior to dispensing drugs, the Contractor shall make a decision to approve,

modify or deny the pharmacy's authorization request by telephone or other electronic means within 24 hours of receipt of the request.

2) The Contractor shall provide authorization for pharmacy Providers to dispense at least a 72-hour emergency supply of drugs, using override codes and without the need to contact the Contractor's pharmacy benefit manager for approval, pending resolution of a prior authorization request and shall provide payment to pharmacy Providers for such dispensed emergency supplies. The Contractor shall have policies and procedures that allow for a greater than a 72-hour emergency supply as determined appropriate in the pharmacist's professional judgment.

3) Upon 72 hour notice from EOHHS and for such periods of time as EOHHS directs, the Contractor shall provide for pharmacy Providers to dispense up to a 30-day emergency supply of drugs, using override codes and without the need to contact the Contractor's pharmacy benefit manager for approval, pending resolution of a prior authorization request and shall provide payment to pharmacy Providers for such dispensed emergency supplies.

i. Establish and maintain pharmacy "lock-in" procedures consistent with MassHealth's controlled substance management program described at 130 CMR 406.442 using the criteria for enrollment equivalent to MassHealth criteria listed on the MassHealth Drug List. Such procedures shall include processes that identify potential fraud or abuse by Enrollees, and review such Enrollees to see whether enrollment in "lock-in" is appropriate.

j. Provide EOHHS with information on Enrollees in a controlled substance management program, as specified by EOHHS and in a form and format and at a frequency specified by EOHHS and in accordance with **Appendix A**; and

k. As further specified by EOHHS, participate in planning efforts with EOHHS about a prescriber "lock-in" program and, as determined by and as further specified by EOHHS, establish and maintain such program.

l. As further specified by EOHHS, implement prior authorization requirements and other utilization management requirements for various clinical initiatives including, but not limited to, the Pediatric Behavioral Health Medication Initiative and monitoring programs. The Contractor shall provide such requirements to EOHHS in a form, format, and frequency specified by EOHHS and in accordance with **Appendix A**.

m. 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 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

   b) Monitoring antipsychotic medications in children by continuing to implement the Pediatric Behavioral Health Medication Initiative (PBHMI), a program to monitor antipsychotic medications in children, as described in **Section 2.7.B.3.l**; and

3) Fraud and abuse identification requirements, including but not limited to, having a process that identifies potential Fraud or Abuse by Enrollees, Providers, and pharmacies; and

4) Any required claims review automated processes.

n. Cover all current and future formulations of drugs prescribed or administered for Medication for Opioid Use Disorder (MOUD) that are approved for the treatment of opioid use disorder (OUD) under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all current and future formulations of biological drugs prescribed or administered for MOUD that are licensed for the treatment of OUD under section 351 of the Public Health Service Act (42 U.S.C. 262), including all formulations of Naltrexone, Buprenorphine, and Methadone prescribed or administered for MOUD.

o. As further directed by EOHHS, the Contractor shall establish policies to prevent Enrollees from paying pharmacies out-of-pocket for medications, including medications reported to the Massachusetts Prescription Awareness tool (MassPAT), when coverage is not available, including but not limited to policies

requiring explicit verification that coverage is not available.

4. Network

   a. The Contractor shall contract with pharmacies in order to provide access throughout the Contractor's Service Area(s) as described in **Section 2.10.C**;

   b. The Contractor may propose to maintain a specialty pharmacy program for its Enrollees. If contracted with a Specialty Pharmacy for certain drugs, the Contractor shall ensure those contracts allow flexibility to implement policies required by EOHHS, including, but not limited to the following:

      1) The Contractor's specialty pharmacy program shall allow an Enrollee to designate a Provider or other representative who may be able to verify need, confirm, or accept deliveries on their behalf.

      2) The Contractor's specialty pharmacy program shall have the ability to provide a drug at the retail level when an Enrollee needs access to the medication in less than 24 hours.

      3) If the Contractor covers a drug as a specialty pharmacy benefit, the Contractor shall allow Enrollees to receive the first-fill at any pharmacy and not just at its specialty pharmacies to the extent allowed by manufacturer limitations. First-fill is defined as a new start or a re-initiation of therapy. EOHHS may, at its discretion, expand this requirement beyond first-fill for all or specified drugs.

5. 340B Drug Pricing Program

   The Contractor shall:

   a. Unless otherwise directed by EOHHS, establish and pay Provider rates for pharmacies associated with entities enrolled in the federal 340B Drug Pricing Program at or above the Provider rates the Contractor pays to pharmacies who are not associated with entities enrolled in the federal 340B Drug Pricing Program;

   b. With respect to drug classes specified by EOHHS, provide coverage in a manner that maximizes EOHHS's ability to collect drug rebates, including but not limited to excluding such drug classes from reimbursement through the Contractor's 340B program, as further specified by EOHHS;

   c. Not reimburse pharmacies associated with Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) and enrolled in the federal 340B Drug Pricing Program, as determined by EOHHS, for drugs purchased through the federal 340B Drug Pricing Program. For purposes of this section, pharmacies

associated with FQHCs or RHCs include, but are not limited to, pharmacies with a contractual relationship with an FQHC or RHC and pharmacies at the same location as an FQHC or RHC;

d. Consistent with **Section 2.8.F**, pay FQHCs and Rural Health Centers (RHCs) at least the amount MassHealth would pay for prescribed drugs on a fee-for-service basis. Specifically, the Contractor shall pay FQHCs and RHCs for prescribed drugs not obtained through the federal 340B Drug Pricing Program at least the amount derived using one of the following methodologies:

   1) the National Drug Average Acquisition Cost (NADAC) of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or

   2) the wholesale acquisition cost (WAC) of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or

   3) the usual and customary charge.

e. Requirements Related to 340B Contract Pharmacies

   For all 340B covered entities that use contract pharmacies, the Contractor shall:

   1) Identify the 340B covered entity connected to claims for drugs purchased through the federal 340B Drug Pricing Program in contract pharmacies at the claim level in a way approved by EOHHS.

   2) As further specified by EOHHS, ensure that all contracts between the 340B covered entity and a contract pharmacy be in writing, ensure continuity of care, and specify that payment to the contract pharmacy constitutes payment in full for 340B drugs provided to Enrollees.

   3) Report any contract pharmacy arrangements to EOHHS in a form specified by EOHHS. These arrangements are subject to EOHHS approval.

   4) Require the contract pharmacy to add 340B indicators, as directed by EOHHS, to all 340B claims.

   5) Require the 340B covered entity to attest that in aggregate the contract pharmacy's margin is less than 20% of the difference between the 340B actual acquisition cost (340B AAC) as defined in 101 CMR 331.02 for drugs purchased through the federal 340B Drug Pricing Program and the rate paid by the Contractor. For the calculation of this margin, any dispensing fee shall be excluded from the rate paid by the Contractor.

   6) Require the 340B covered entity to report to the Contractor how the

margins retained by the 340B covered entity relating to drugs purchased through the federal 340B Drug Pricing Program are being used, in such manner as specified by EOHHS. The Contractor shall report such information to EOHHS.

6. Reporting and Analysis

The Contractor shall:

a. Include data collection, analysis, and reporting functions related to individual and aggregate physician prescribing and Enrollee utilization, to identify Enrollees who would benefit from Disease Management or Case Management interventions;

b. Provide EOHHS with reports specified in this **Section 2.7.B** and **Appendix A**.

c. Respond to requests by EOHHS for custom reports, particularly in support of cooperative data analysis efforts; and

d. Provide to EOHHS, in accordance with **Appendix A**, a geographic access report of the Contractor's pharmacy network.

e. Pharmacy Benefits Manager Pricing Report

As further specified by EOHHS, the Contractor shall, in accordance with **Appendix A** and in a form, frequency, and format specified by EOHHS, submit a Pharmacy Benefits Manager Pricing Report. The Pharmacy Benefits Manager Pricing Report shall include, but may not be limited to, the following information as further specified by EOHHS:

1) At the Claim level:

a) Payments to each dispensing pharmacy by the PBM; and

b) Payments to the PBM by the Contractor

2) At the National Drug Code level:

a) Volume of drugs;

b) Rebate dollar amounts received by the PBM from any manufacturer; and

c) Rebate dollar amounts paid to the Contractor by the PBM

3) At the aggregate level:

a) Any administrative payments made to the Contractor by any PBM or to any PBM by the Contractor; and

b) Any administrative payments made to a dispensing pharmacy contracted with the Contractor by any PBM contracted with the Contractor or to any PBM contracted with the Contractor from any dispensing pharmacy contracted with the Contractor

7. Mail Order Pharmacy Program

The Contractor may propose to develop a voluntary mail order pharmacy program for the Contractor's Enrollees in accordance with EOHHS requirements. Pharmacy co-payments shall be in the same amounts as the pharmacy co-payments established by EOHHS for Members not enrolled in an Accountable Care Partnership Plan or MassHealth-contracted MCO. See 130 CMR 450.130. The Contractor shall continue to assure adequate access to pharmacy services for all Enrollees, regardless of whether the Enrollee chooses to receive mail order pharmacy services.

a. As a part of its proposal, the Contractor shall submit to EOHHS a description of the mail order pharmacy program. At a minimum, such description shall include:

1) A proposed time frame for implementing the mail order pharmacy program;

2) The drugs included and excluded in such a mail order pharmacy program, including specialty and non-specialty mail-order drugs;

3) How the Contractor plans to address the following issues:

a) Pharmaceutical diversion and early refills;

b) First-fill allowances at any pharmacy consistent with this **section**;

c) Emergency refills; and

d) Access to pharmacist counseling on the proper use of medication, including drug interaction safety;

4) A draft of notices to Enrollees about the mail order pharmacy program;

5) A description of training on the mail order pharmacy program to all employees, including customer service representatives, the pharmacy benefit manager, and Providers; and

6) A brief description of the methods by which the Contractor will assure compliance with all applicable requirements of this Contract and federal and state law.

b. The mail order pharmacy program is subject to EOHHS's review and prior approval. EOHHS, in its sole discretion, may accept all, part, or none of a

Contractor's proposed mail order pharmacy program.

c. If the Contractor establishes a mail order pharmacy program that includes specialty drugs, the Contractor's program shall comply with the requirements in **Section 2.7.B.4.b**.

d. If the Contractor establishes a mail order pharmacy program, the Contractor shall submit the mail order pharmacy report in the form and format described in **Appendix A**, and any other ad hoc reports as directed by EOHHS.

8. Pharmacy Co-payments

The Contractor shall:

a. Implement co-payments for pharmacy services as provided in **Section 5.1.K.2**;

b. On a nightly basis, transmit the Daily Inbound Copay File as specified in **Appendix J**.

c. Include provisions in all Provider Contracts with pharmacies that prohibit the pharmacy from denying prescription drugs to Enrollees based on an Enrollee's inability to pay their co-payment; and

d. Develop written standard operating procedures for addressing pharmacies that repeatedly deny prescription drugs to Enrollees based on the Enrollee's reported inability to pay the pharmacy co-payment. Such standard operating procedures shall include:

1) A process for outreaching to the Enrollee and ensuring availability of the needed prescription drugs in a timely manner;

2) Reminding the pharmacy that denying prescription drugs to Enrollees based on an Enrollee's inability to pay their co-payment is a violation of its Provider Contract with the Contractor;

3) Providing EOHHS with a list of any pharmacies that demonstrate a pattern of inappropriately denying prescription drugs to Enrollees, and the steps taken to resolve the situation; and

4) Taking disciplinary action against the noncompliant pharmacy, if necessary.

9. Obligations of the ACOs to Support Rebate Collection

The Contractor shall take all steps necessary to participate in, and support EOHHS' participation in, federal and supplemental drug rebate programs and to participate in and support any rebate program for Non-Drug Pharmacy Products (including, but not

limited to, blood glucose test strips) as directed by EOHHS and as follows:

a. The Contractor shall ensure EOHHS obtains all drug and Non-Drug Pharmacy Product utilization data in accordance with the requirements set forth by EOHHS. The Contractor shall participate and cooperate with EOHHS in activities meant to assist EOHHS with identifying and appropriately including eligible drug claims in the federal drug rebate program and eligible claims for Non-Drug Pharmacy Product rebates.

b. The Contractor shall perform all system and program activities determined necessary to:

    1) Properly identify drugs purchased through the Federal 340B Drug Pricing Program; and

    2) Collect all of the following information on claims for physician-administered drugs and deny any claim for such drugs that does not include all such information:

        a) All information set forth in 42 CFR 447.511 that EOHHS specifies the Contractor needs to provide, including but not limited to National Drug Code (NDC),

        b) Metric Quantity, and

        c) Unit of Measure.

c. The Contractor shall take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize drug and Non-Drug Pharmacy Product rebate collection. Such steps shall include:

    1) Covering all prescription drugs, Non-Drug Pharmacy Products and over-the-counter drugs uniformly with how EOHHS covers such drugs and products for MassHealth fee-for-service Members as set forth in the MassHealth Drug List, including but not limited to the drugs and products themselves and any utilization management and authorization requirements for such drugs and products, including but not limited to:

        a) Designating drugs and Non-Drug Pharmacy Products as Preferred Drugs and Non-Drug Pharmacy Products consistent with the MassHealth Drug List or as otherwise specified by EOHHS, and changing such designation as directed by EOHHS; and

        b) Developing and implementing Prior Authorization requirements and other Utilization Management requirements, such as step

therapy, on preferred and non-preferred drugs within the designated therapeutic classes identified in the MassHealth Drug List and drugs identified in the MassHealth Acute Hospital Carve-Out Drugs List or as otherwise specified by EOHHS;

c) Developing and implementing Prior Authorization requirements and other Utilization Management requirements on preferred and non-preferred Non-Drug Pharmacy Products identified in the MassHealth Drug List or as otherwise specified by EOHHS;

2) Excluding certain drugs or drug classes, set forth in the MassHealth Drug List or as otherwise specified by EOHHS, from reimbursement through the Contractor's 340B program;

3) Terminating, and not entering into, rebate agreements with its PBMs or with manufacturers for drugs or drug classes if directed by EOHHS;

4) Terminating, and not entering into, rebate agreements with its PBMs or with manufacturers for Non-Drug Pharmacy Products set forth in the MassHealth Drug List if directed by EOHHS;

5) Signing up to receive notifications from EOHHS of changes to the MassHealth Drug List;

6) Taking any other steps that are necessary for EOHHS to maximize rebate collection.

d. The Contractor shall adhere to the Drug and Non-Drug Pharmacy Product Rebate contractual requirements set forth in **Section 2.15.C.7**.

e. Pharmacy Utilization Incentive and Capitation Payment Deduction

1) The Contractor shall make all appropriate efforts to meet the EOHHS-specified MassHealth fee-for-service (FFS) utilization percentages per therapeutic class for the Contract Year, and corresponding rebate amounts, as set and directed by EOHHS for the covered drugs and Non-Drug Pharmacy Products set forth in the MassHealth Drug List as specified by EOHHS.

2) EOHHS shall calculate, for the covered drugs and Non-Drug Pharmacy Products set forth in the MassHealth Drug List as specified by EOHHS:

a) at least quarterly, the MassHealth FFS utilization percentage per therapeutic class for the Contract Year and provide such percentages to the Contractor.

b) for the Contract Year, whether the Contractor met the

MassHealth FFS utilization percentage per therapeutic class, and corresponding rebate amounts, based on MassHealth FFS actual utilization for the Contract Year.

(i) For such calculations, EOHHS shall use quarterly Encounter Data to determine whether the Contractor's actual utilization per therapeutic class, and actual rebate amounts, are within a -/+1.5% range of the MassHealth FFS actual utilization for the Contract Year and corresponding rebate amounts. Such calculation may be done at the NDC or drug level and at the thirty-day supply level. (e.g., Encounter Data showing a ninety-day supply will be considered three thirty-day supplies).

(ii) EOHHS shall provide the Contractor with a report showing the results.

3) If the Contractor is below 98.5% of the MassHealth FFS utilization for the Contract Year, and corresponding rebate amounts, normalized and as further specified by EOHHS, EOHHS shall apply a Capitation Payment deduction in accordance with **Section 5.4**.

4) If the Contractor is above 101.5% of the MassHealth FFS utilization for the Contract Year and corresponding rebate amounts, normalized and as further specified by EOHHS, EOHHS shall pay the Contractor in accordance with **Section 4.6.D**.

5) The calculation of a Capitation Payment deduction and payment described above shall exclude drugs purchased through the federal 340B Drug Pricing Program.

C. Authorization of Services

In accordance with 42 CFR 438.210, the Contractor shall authorize services as follows:

1. For the processing of requests for initial and continuing authorizations of ACO Covered Services, the Contractor shall:

   a. Have in place and follow written policies and procedures;

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

   c. Consult with the requesting Provider when appropriate.

2. The Contractor shall ensure that a physician and a behavioral health specialist are

available 24 hours a day for timely authorization of Medically Necessary services and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary.

3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health Services denials shall be rendered by board certified or board eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health Services being denied, including as set forth in **Section 2.7.D.5**, except in cases of denials of service for psychological testing which shall be rendered by a qualified psychologist.

4. For any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, the Contractor shall make best efforts to work with the requesting Provider, the Enrollee, and/or the Enrollee's care team to ensure the Enrollees needs are met. Such efforts may include but not be limited to authorizing alternative treatment or educating the Provider on proper authorization request submission

5. The Contractor shall notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of, any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404 and **Section 2.13.B.2**, and shall:

    a. Be produced in a manner, format, and language that may be easily understood;

    b. Be made available in non-English languages, upon request; and

    c. Include information, in non-English languages about how to request translation services and Alternative Formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency.

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

    a. Except as otherwise specified in **Section 2.7.C.6.b**, for standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than 14 calendar days after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:

        1) The Enrollee or the Provider requests an extension, or

        2) The Contractor can justify (to EOHHS upon request) that:

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

b) There is a need for additional information where:

(i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

(ii) Such outstanding information is reasonably expected to be received within 14 calendar days.

b. For expedited service authorization decisions, where the Provider indicates, or the Contractor determines, that following the standard timeframe in paragraph a. above, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than 72 hours after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:

1) The Enrollee or the Provider requests an extension; or

2) The Contractor can justify (to EOHHS upon request) that:

a) The extension is in the Enrollee's interest; and

b) There is a need for additional information where:

(i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

(ii) Such outstanding information is reasonably expected to be received within 14 calendar days.

c. For pharmacy-related authorizations, in accordance with this **Section 2.7.C** and the timeframes in **Section 2.7.B.3**.

d. In accordance with 42 CFR part 438 and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the Contractor shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

7. The Contractor and its Behavioral Health Material Subcontractor, if any, shall provide Medical Necessity criteria for prior authorization upon the request of an Enrollee, a MassHealth Provider, or the MassHealth agency. This requirement may be fulfilled by publishing the criteria on the Contractor's website.

8. For all covered outpatient drug authorization decisions, the Contractor shall provide

notice as described in Section 1927(d)(5)(A) of the Social Security Act; and

9. For any Enrollees that disenroll from the Contractor to enroll in the MassHealth PCC Plan, a MassHealth-contracted MCO, or another Accountable Care Partnership Plan, the Contractor shall develop, implement, and maintain policies and procedures for sharing information on service authorizations with MassHealth or such MCO or such Accountable Care Partnership Plan;

D. Utilization Management

The Contractor shall maintain a Utilization Management plan and procedures consistent with the following:

1. Staffing of all Utilization Management activities shall include, but not be limited to, a Medical Director, or Medical Director's designee. The Contractor shall also have a Medical Director's designee for Behavioral Health Utilization Management. All staff performing Utilization Management activities shall:

   a. Comply with all federal, state, and local professional licensing requirements;

   b. Include representatives from, and where appropriate input from, specialty areas. Such specialty areas shall include, at a minimum, cardiology, epidemiology, OB/GYN, pediatrics, addictionology, child and adolescent psychiatry, and adult psychiatry;

   c. Have appropriate expertise in managed care, peer review activities, or both;

   d. Not have had any disciplinary actions or other type of sanction ever taken against them, in any state or territory, by the relevant professional licensing or oversight board or the Medicare and Medicaid programs; and

   e. Not have any legal sanctions relating to their professional practice including, but not limited to, malpractice actions resulting in entry of judgment against them, unless otherwise agreed to by EOHHS.

2. In addition to the requirements set forth in paragraph 1 above, the Medical Director's designee for behavioral health Utilization Management shall also:

   a. Be board certified or board eligible in psychiatry;

   b. Be available 24 hours per day, seven days a week for consultation and decision-making with the Contractor's clinical staff and Providers; and

   c. Meet the requirements, and ensure its staff meets the requirements, set forth in **Section 2.7.D.5** below.

3. The Contractor shall have in place policies and procedures that include at a minimum the elements listed below. The Contractor shall submit such policies and procedures to

EOHHS upon request. The Contractor shall also share such policies and procedures with its ACO Partner, as appropriate, and consider feedback, if any, provided by the ACO Partner.

a. Routinely assess the effectiveness and the efficiency of the Utilization Management program;

b. Evaluate the appropriate use of medical technologies, including medical procedures, Behavioral Health treatments, drugs, and devices;

c. Target areas of suspected inappropriate service utilization;

d. Detect both over- and under-utilization;

e. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

f. Compare Enrollee and Provider utilization with norms for comparable individuals;

g. Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services, and out-of-Network services, as well as Behavioral Health Inpatient and Outpatient Services, Diversionary Services, and ESPs;

h. Ensure that treatment and Discharge Planning are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP and other Providers as appropriate;

i. Conduct retrospective reviews of the medical records of selected cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care;

j. Refer suspected cases of Provider or Enrollee Fraud or Abuse to EOHHS within five business days;

k. Address processes through which the Contractor monitors issues identified by the Contractor, EOHHS, Enrollees, and Providers, including the tracking of issues and resolutions over time; and

l. Are communicated, accessible, and understandable to internal and external individuals, and entities, as appropriate.

4. The Contractor's Utilization Management activities shall include:

a. Referrals and coordination of ACO and Non-ACO Covered Services;

b. Authorization of ACO Covered Services, including modification or denial of

requests for such services;

c. Assisting care teams with inpatient Discharge Planning;

d. Behavioral health treatment and Discharge Planning;

e. Monitoring and assuring the appropriate utilization of specialty services, including Behavioral Health Services;

f. Notwithstanding any other provision contained herein, the Contractor may not establish utilization management strategies that require Enrollees to 'fail-first' or participate in 'step therapy' as a condition of providing coverage for injectable naltrexone (Vivitrol™). Contractor shall cover Vivitrol™ as a pharmacy and medical benefit. If the Contractor covers Vivitrol™ as a specialty pharmacy benefit, the Contractor shall allow Enrollees to do a first-fill at any pharmacy, not just at specialty pharmacies. First fill is defined as a new start or a re-initiation of therapy.

g. Providing training and supervision to the Contractor's Utilization Management clinical staff and Providers on:

1) The standard application of Medical Necessity criteria and Utilization Management policies and procedures to ensure that staff maintain and improve their clinical skills;

2) Utilization Management policies, practices and data reported to the Contractor to ensure that it is standardized across all Providers within the Contractor's Provider Network; and

3) The consistent application and implementation of the Contractor's Clinical Criteria and guidelines including the Behavioral Health Clinical Criteria approved by EOHHS;

h. Monitoring and assessing Behavioral Health Services and outcomes measurement, specifically using the CANS Tool for Enrollees under 21, and using any standardized clinical outcomes measurement tools that are submitted by Providers and reviewed and approved by the Contractor for Enrollees aged 21 or older. The Contractor's Behavioral Health Services Provider Contracts shall stipulate that the Contractor may access, collect, and analyze such behavioral health assessment and outcomes data for quality management and Network Management purposes;

5. The Contractor shall ensure that clinicians conducting Utilization Management who are coordinating Behavioral Health Services, and making Behavioral Health Service authorization decisions, have training and experience in the specific area of Behavioral Health Service for which they are coordinating and authorizing Behavioral Health

Services. The Contractor shall ensure the following:

a. That the clinician coordinating and authorizing adult mental health services shall be a clinician with experience and training in adult mental health services;

b. That the clinician coordinating and authorizing child and adolescent mental health services shall be a clinician with experience and training in child and adolescent mental health services and in the use of the CANS Tool;

c. That the clinician coordinating and authorizing adult substance use disorders shall be a clinician with experience and training in adult substance use disorders;

d. That the clinician coordinating and authorizing child and adolescent substance use disorders shall be a clinician with experience and training in child and adolescent substance use disorders; and

e. That the clinician coordinating and authorizing services for Enrollees with Co-Occurring Disorders shall have experience and training in Co-Occurring Disorders.

6. The Contractor shall have policies and procedures for its approach to retrospective utilization review of Providers. Such approach shall include a system to identify utilization patterns of all Providers by significant data elements and established outlier criteria for all services.

7. The Contractor shall have policies and procedures for conducting retrospective and peer reviews of a sample of Providers to ensure that the services furnished by Providers were provided to Enrollees, were appropriate and Medically Necessary, and were authorized and billed in accordance with the Contractor's requirements.

8. The Contractor shall have policies and procedures for conducting monthly reviews of a random sample of no fewer than 500 Enrollees to ensure that such Enrollees received the services for which Providers billed with respect to such Enrollees.

9. The Contractor shall monitor and ensure that all Utilization Management activities provided by a Material Subcontractor comply with all provisions of this Contract.

10. The Contractor shall participate in any workgroups, task forces, and meetings related to Utilization Management and best practices, as requested by EOHHS. The Contractor shall review and align its Utilization Management policies and procedures to align with any recommendations of such group.

11. The Contractor shall conduct the utilization activities set forth below, as further specified by EOHHS.

    a. The Contractor shall develop and implement a process for monitoring and addressing high Emergency Department (ED) utilization.

b. The Contractor shall conduct, for acute inpatient level of care, pre-admission screening for all elective medical and surgical admissions and, for acute rehabilitation level of care, shall conduct pre-admission screening and concurrent review, as follows:

1) Pre-admission screening shall be conducted in accordance with 130 CMR 450.207 and 130 CMR 450.208 and shall review for medical necessity and appropriate setting on all medical and surgical elective admissions to all acute hospitals for all Enrollees, including for out-of-state services, except for the elective admissions of:

a) Enrollees for whom EOHHS is not the primary payer of the acute hospital admission, including but not limited to Enrollees covered by an MCO, an Accountable Care Partnership Plan, commercial insurance, or Medicare;

b) Enrollees who are recipients of the Emergency Aid to the Elderly, Disabled, and Children Program;

c) Enrollees whose hospitalization is court ordered; and

d) Delivery-related admissions of Enrollees.

2) Concurrent reviews shall be the assessment of the medical necessity for a continued hospital stay at acute rehabilitation level of care and for all services provided during such continued stay. Such review may be performed at any time subsequent to the Enrollee's admission.

c. At a frequency and in a form and format specified by EOHHS, the Contractor shall calculate and report to EOHHS the measures specified below, in accordance with any specifications provided by EOHHS. The Contractor shall also report on any programs the Contractor has in place addressing adverse trends identified through this analysis.

1) Inpatient Admissions.

a) Surgical Admissions: total admissions, admissions/1000, and Per Member Per Month costs

b) Medical Admissions: total admissions, admissions/1000, and Per Member Per Month costs

2) Primary Care Visits: total visits, visits/1000, and Per Member Per Month costs

3) Home Health Services.

a) Skilled Nursing Visits: total visits, visits/1000, and Per Member

Per Month costs

b) Home Health Aide Visits: total visits, visits/1000, and Per Member Per Month costs

c) Physical, Occupational and Speech Therapy Visits (as part of Home Health): total visits, visits/1000, and Per Member Per Month costs

4) Radiology Outpatient Services.

a) Computerized Axial Tomography Visits (CPT codes 70450 through 70470, 70480 through 70498, 71250 through 71275, 72125 through 72133, 72191 through 72194, 73200 through 73206, 73700 through 73206, 73700 through 73706, 74150 through 74178, 74261 through 74263, 75571 through 75574, 77011 through 77014, 0066T, 0067T, 76380, 77078, G0288): total visits, visits/1000, and Per Member Per Month costs

b) Magnetic Resonance Imaging Visits (CPT codes 70540 through 70559, 71550 through 71555, 72141 through 72159, 72195 through 72197, 73218 through 73225, 73718 through 73725, 74181 through 74185, 75557 through 75565, C8903 through C8908, 72198, 76390, 77021, 77084): total visits, visits/1000, and Per Member Per Month costs

c) Positron Emission Tomography Visits (CPT codes 78608 through 78816, 78491, 78492, 78459): total visits, visits/1000, and Per Member Per Month costs

d) Nuclear Cardiology (MUGA scans, perfusion imaging) Visits (CPT codes 78414, 78428, 78451 through 78754, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496, 78499): total visits, visits/1000, and Per Member Per Month costs

e) Magnetic Resonance Angiography Visits (CPT codes 74185, 73225, 71555, 70544 – 70546, 73725, 70547-70549, 72198, 72159): total visits, visits/1000, and Per Member Per Month costs

5) Outpatient Therapy Services

a) Physical Therapy Visits: total visits, visits/1000, and Per Member Per Month costs

b) Occupational Therapy Visits: total visits, visits/1000, and Per Member Per Month costs

c) Speech Therapy Visits: total visits, visits/1000, and Per Member Per Month costs

6) Laboratory and Pathology: total claims, claims/1000, and Per Member Per Month costs

7) Behavioral Health:

a) Behavioral Health Inpatient Admissions: admissions, admissions/1000, and Per Member Per Month costs

b) Behavioral health penetration rate per 1000

c) Average length of stay for a Behavioral Health inpatient stay

d. The Contractor shall identify high utilizers and indicate to EOHHS goals and processes to reduce utilization by these Enrollees. The Contractor shall:

1) Define high utilizers as the top 3% in overall expenditures for the Calendar Year;

2) As further specified by EOHHS, report to EOHHS, for the Calendar Year:

a) The number of Enrollees identified,

b) The services those Enrollees received, and

c) The total costs for those Enrollees;

3) Identify new high utilizers at a minimum twice annually;

4) Examine utilization patterns of Enrollees and identify and monitor those at risk of being high utilizers.

E. Behavioral Health Services: Authorization Policies and Procedures

The Contractor shall, in addition to applicable requirements in **Sections 2.7.C-D** above:

1. Review and update annually, at a minimum, the clinical criteria definitions and program specifications for each Behavioral health ACO Covered Service. The Contractor shall submit any modifications to these documents to EOHHS annually for review and approval. In its review and update process, the Contractor shall consult with its clinical staff or medical consultants outside of the Contractor's organization, or both, who are familiar with standards and practices of mental health and substance use disorder treatment in Massachusetts;

2. Review and update annually, at a minimum, and submit for EOHHS approval, its Behavioral Health Services authorization policies and procedures;

3. Develop and maintain Behavioral Health Inpatient Services and 24-Hour Diversionary Services authorization policies and procedures, which shall, at a minimum:

    a. If prior authorization is required for any Behavioral Health Inpatient Services admission or 24-Hour Diversionary Service, assure the availability of such prior authorization 24 hours a day, seven days a week;

    b. Include a plan and a system in place to direct Enrollees to the least intensive but clinically appropriate service;

    c. For all Behavioral Health emergency inpatient admissions, ensure:

        1) A system to provide an initial authorization, where applicable, and communicate the initial authorized length of stay to the Enrollee, facility, and attending physician. Such initial authorization and communication shall be provided verbally within 30 minutes for emergency admissions, and within 2 hours for non-emergency inpatient admissions and in writing within 24 hours of all admissions;

        2) Policies and procedures to ensure compliance by the Contractor and any of the Contractor's Material Subcontractors with **Section 2.7.E.3.c.1**;

    d. Ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available;

    e. Include a system to concurrently review Behavioral Health Inpatient Services to monitor Medical Necessity for the need for continued stay, and achievement of Behavioral Health Inpatient treatment goals;

    f. Ensure verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans and 24-Hour Diversionary Services treatment plans;

    g. Ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP and other members of the care team;

    h. Ensure retrospective reviews of the medical records of selected Behavioral Health Inpatient Services admissions and 24-Hour Diversionary Services cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care;

    i. Ensure prior authorization shall not be required for Inpatient Substance Use Disorder Services (Level 4), Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7), Clinical Support Services for Substance Use Disorders

(Level 3.5), and Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) as defined in **Appendix C**;

j. Ensure Providers providing Clinical Support Services for Substance Use Disorders (Level 3.5) shall provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee; and

k. If utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level 3.5), ensure such activities may be performed no earlier than day 7 of the provision of such services.

l. Monitor the rates of authorization, diversion, modification and denial at the service level for each such service, and for reporting to EOHHS in accordance with **Appendix A**.

m. Not require prior authorization for Community Based Acute Treatment (CBAT), and Intensive Community Based Acute Treatment (ICBAT) as set forth in **Appendix C**. The Contractor shall require Provides providing CBAT and ICBAT to provide the Contractor, within 72 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee.

n. Not require prior authorization for Inpatient Mental Health services as set forth in **Appendix C**. The Contractor shall require Providers of Inpatient Mental Health services to provide the Contractor, within 72 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee.

4. Develop and maintain non-24-Hour Diversionary Services authorization policies and procedures. Such policies and procedures shall be submitted to EOHHS for review and approval;

5. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

a. Policies and procedures to automatically authorize at least 12 sessions of Behavioral Health Outpatient Services;

b. Policies and procedures for the authorization of all Behavioral Health Outpatient Services beyond the initial 12 Outpatient Services;

c. Policies and procedures to authorize Behavioral Health Outpatient Services based upon behavioral health Clinical Criteria; and

d. Policies and procedures based upon behavioral health Clinical Criteria to review

and approve or deny all requests for Behavioral Health Outpatient Services based on Clinical Criteria.

6. Implement defined Utilization Management strategies for CBHI Services that are standardized across all MassHealth managed care entities.

7. The Contractor shall cover medically necessary preventive behavioral health services for members from birth until age 21, or their caregiver, as outlined in **Appendix C** and as further specified by EOHHS, including, but not limited to, as specified in MassHealth Managed Care Entity (MCE) Bulletin 65. The Contractor shall cover up to six sessions of preventive behavioral health services without requiring prior authorization or a diagnostic assessment, such as the CANS (Child and Adolescent Strengths and Needs). After six sessions, the Contractor may require the Provider to submit documentation to support the clinical appropriateness of ongoing preventive services. The Contractor may require Providers to complete a diagnostic assessment, including the CANS, as part of the Contractor's determination of the ongoing need for preventive services.

F. Services for Specific Populations

1. The Contractor shall provide or arrange health care services to MassHealth Standard and CommonHealth Enrollees under the age of 21, in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements at 42 CFR 441.56(b) and (c), and 130 CMR 450.140 et seq., as those regulations may be amended, ensuring that its Providers do the same. This shall include, but shall not be limited to ensuring that Primary Care, including EPSDT screenings are delivered according to the EPSDT Periodicity Schedule.

2. At the direction of EOHHS, actively participate in initiatives, processes and activities of Commonwealth agencies with which Enrollees have an affiliation. Such agencies include, but are not limited to:

   a. The Department of Mental Health (DMH);

   b. The Department of Children and Families (DCF);

   c. The Department of Youth Services (DYS);

   d. The Department of Public Health and DPH's Bureau of Substance Addiction Services (DPH/BSAS);

   e. The Department of Developmental Disabilities (DDS);

   f. The Massachusetts Rehabilitation Commission (MRC);

   g. The Massachusetts Commission for the Blind (MCB);

   h. The Department of Veterans Services (DVS);

i. The Department of Probation;

j. The Department of Housing and Community Development (DHCD);

k. The Department of Transitional Assistance (DTA);

l. The Executive Office of Elder Affairs; and

m. The Massachusetts Commission on the Deaf and Hard of Hearing.

3. When an Enrollee is involved with one or more EOHHS agency, including but not limited those listed above, notify such agencies of an Enrollee's admission to an inpatient facility within one business day of the facility's admission notification with respect to such Enrollee;

4. Ensure that services are provided to children in the care or custody of DCF, and youth affiliated with DYS (either detained or committed), as follows:

   a. Ensure that Providers make best efforts to provide the 7-day medical screenings and 30-day comprehensive medical evaluations, which shall include the EPSDT screens appropriate for the child's age, for their Enrollees who are taken into DCF custody;

   b. In addition to the Continuity of Care requirements set out in **Section 2.4.F**, Cover Primary Care services when provided by out-of-network providers for 30 days after an Enrollee is taken into DCF custody, without requiring any prior approval or permission to see such out-of-network provider.

   c. Make best efforts to provide foster parents with current medical information about the Enrollees placed in their care in a timely manner;

   d. Ensure that Providers make best efforts to communicate with the DCF caseworker(s) assigned to Enrollees in DCF care or custody and inform them of services provided through the Contractor's Plan;

   e. Ensure that Providers make best efforts to communicate with the DYS caseworker(s) assigned to Enrollees in DYS and inform them of services provided through the Contractor's Plan;

5. For Enrollees with DMH affiliation, ensure that Providers make best efforts to communicate with the DMH caseworker(s) assigned to Enrollees and inform them of the services provided through the Contractor's Plan.

6. Provide or arrange preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, in accordance with EPSDT and PPHSD guidelines for individuals under age 21, other guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards

of practice;

7. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice;

8. Comply with the Early Intervention (EI) requirements set forth in 130 CMR 440.00, as those regulations may be amended, to establish and maintain a comprehensive, community-based program for MassHealth Standard and CommonHealth Enrollees between the ages of birth and three years, whose developmental patterns are atypical or, are at serious risk to become atypical, through the influence of certain biological or environmental factors;

9. Provide or arrange family planning services as follows:

    a. Ensure that all Enrollees are made aware that:

        1) Family planning services are available to Enrollees through any MassHealth family planning provider, regardless of whether such provider is in the Contractor's network; and

        2) Enrollees do not need authorization in order to receive such services;

    b. Provide all Enrollees with sufficient information about and assistance with accessing family planning services in and out of the Contractor's Provider Network, including how to access such services and available providers;

    c. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to:

        3) All methods of contraception, including sterilization, vasectomy, and emergency contraception;

        4) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and

        5) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination;

    d. Maintain sufficient family planning Providers to ensure timely access to family planning services.

10. Provide systems and mechanisms designed to make medical history and treatment information available to the greatest extent possible at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as people who are homeless; and

11. Comply with the Commonwealth's screening process for placement of individuals aged 21 or younger in pediatric nursing facilities in accordance with 130 CMR 456.408(A)(1).

G. Emergency and Post-Stabilization Care Service Coverage

1. The Contractor shall cover and pay for Emergency Services in accordance with 42 CFR 438.114 and Mass. Gen. Laws Ch. 118E, section 17A.

2. The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor. The Contractor shall pay a non-contracted provider of Emergency and Post-Stabilization Services an amount equal to or, if the Contractor can negotiate a lower payment, less than the amount allowed under the state's Fee-For Service rates, less any payments for indirect costs of medical education and direct costs of graduate medical education. The Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.

3. The Contractor shall not deny payment for treatment for an Emergency Medical Condition.

4. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

5. 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.

6. 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.

7. 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:

    a. Is consistent with generally accepted principles of professional medical practice; and

    b. Is a covered benefit under the Contract.

8. The Contractor shall cover and pay for Post-Stabilization Care Services in accordance with 42 CFR 438.114(e), 42 CFR 422.113(c), and Mass. Gen. Laws Ch. 118E, section 17A.

H. Nursing Facility Stay

If it appears that an Enrollee's stay in a nursing facility may exceed 100 days of service within a calendar year, the Contractor shall:

1. Outreach to the Provider to determine whether the Enrollee's stay is anticipated to exceed 100 days within the calendar year; and

2. Prior to the Enrollee receiving 100 days of service at the facility, submit the MassHealth SC-1 and screening forms to EOHHS in a form and format specified by EOHHS and work with the Enrollee and Enrollee's Authorized Representative to ensure the Enrollee has appropriate MassHealth coverage for post-100 day stay.

I. Service Codes

When directed by EOHHS, the Contractor shall cover and use the service codes provided by, and as updated by, EOHHS representing the ACO Covered Services set forth in **Appendix C**. The Contractor shall also use such codes provided by EOHHS when representing any Non-ACO Covered Services or excluded services set forth in **Appendix C**;

J. AND Status Data

As directed by EOHHS, the Contractor shall collect and report data to EOHHS regarding Enrollees on Administratively Necessary Days (AND) status in a 24-hour level of care. The Contractor shall report to EOHHS Member-level reporting on a daily basis through the Massachusetts Behavioral Health Access (MABHA) website, as further specified by EOHHS, and additional information on an ad hoc basis in a form, format, and frequency specified by EOHHS.

K. In Lieu of Services or Settings

1. In accordance with 42 CFR 438.3(e)(2) and 438.6(e) the Contractor may cover the Inpatient Behavioral Health Services set forth in **Appendix C** delivered in Institutions for Mental Disease (IMD), as defined in Section 1905(i) of the Social Security Act, as identified by EOHHS, as an in lieu of service or setting for Enrollees between the ages of 21-64, provided that:

    a. The Contractor does not require Enrollees to receive services in an IMD;

    b. Use of an IMD is a medically appropriate and cost-effective substitute for delivery of the service; and

    c. The length of stay for any Enrollee is no more than 15 days in a calendar month.

2. For any Enrollee between the ages of 21-64 who received the Inpatient Behavioral Health Services set forth in **Appendix C** in an IMD for more than 15 days in any calendar month, the Contractor shall:

    a. Report to EOHHS, in a form and format and at a frequency to be determined by EOHHS:

        1) The Enrollee's rating category;

        2) The length of stay in the IMD in that calendar month; and

3) Any other information requested by EOHHS; and

b. As further specified and directed by EOHHS, reconcile the capitation payment received by the Contractor pursuant to **Section 4.2** for the calendar month in which the Enrollee received the Inpatient Behavioral Health Services set forth in **Appendix C** in an IMD for more than 15 days.

3. IMD settings are set forth in **Appendix G** which may be updated from time to time.

L. Compliance with Federal Regulations for PASRR Evaluations

The Contractor shall comply with federal regulations requiring referral of nursing facility eligible Enrollees, as appropriate, for PASRR evaluation for mental illness and developmental disability treatment pursuant to the Omnibus Budget Reconciliation Act of 1987, as amended, and 42 CFR 483.100 through 483.138. The Contractor shall not pay for nursing facility services rendered to an Enrollee during a period in which the nursing facility has failed to comply with PASRR with respect to that Enrollee. In any instance in which the Contractor denies payment in accordance with this **section**, the Contractor shall ensure that the Provider does not attempt to bill the Enrollee for such services

Section 2.8 Provider Network, Provider Contracts, and Related Responsibilities

A. Provider Network

1. General requirements for the Provider Network

a. The Contractor shall maintain and monitor a Provider Network sufficient to provide all Enrollees, including those with limited English proficiency or physical or mental disabilities, with adequate access to ACO Covered Services. As further directed by EOHHS, the Contractor shall maintain information about its Provider Network with respect to the above requirement and provide EOHHS with such information upon request;

b. The Provider Network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of this Contract. When directed by EOHHS;

1) Such Providers shall be enrolled with EOHHS as specified by EOHHS; and

2) The Contractor may execute Provider Contracts for up to 120 days pending the outcome of EOHHS' enrollment process, but shall terminate a Provider Network immediately upon notification from EOHHS that the Network Provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider. The Contractor shall notify affected Enrollees of the termination.

c. The Provider Network shall include a sufficient number of Providers with

appropriate expertise in treating Enrollees with BH or LTSS needs to address the care needs of such Enrollees;

d. The Contractor shall make best efforts to ensure that SDO-certified businesses and organizations are represented in the Provider Network. The Contractor will submit on a frequency specified by EOHHS the appropriate **Appendix A** certification checklist on its efforts to contract with SDO-certified entities;

e. As requested by EOHHS, the Contractor shall, in a form and format specified by EOHHS and in accordance with **Appendix A**, report to EOHHS data specifications related to its Network Providers including but not limited to whether each Network Provider is enrolled as a MassHealth provider, and any other information requested by EOHHS about its Network Providers including but not limited to each Provider's MassHealth billing ID, provider ID/service location (PID/SL), NPI, tax ID (or TIN), and known affiliations to other providers;

f. In establishing and maintaining the Provider Network, the Contractor shall consider the following:

   1) The anticipated MassHealth enrollment;

   2) The expected utilization of services, taking into consideration the characteristics and health care needs of specific MassHealth populations enrolled with the Contractor;

   3) The numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the ACO Covered Services;

   4) The number of Network Providers who are not accepting new patients; and

   5) The geographic location of Providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities;

g. The Contractor shall implement written policies and procedures for the selection and retention of Providers in accordance with 42 CFR 438.214, including but not limited to ensuring such policies and procedures for Providers do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;

h. The Contractor shall 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. The Contractor shall ensure that Providers do not engage 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. The Contractor shall ensure that the Provider Network provides Enrollees with direct access to a reproductive and gynecological health specialist, including an obstetrician or gynecologist, within the Provider Network for ACO Covered Services necessary to provide routine and preventive health care services. This shall include contracting with, and offering to eligible Enrollees, reproductive and gynecological health specialists as PCPs;

k. The Contractor's Provider Network shall include freestanding birth centers licensed by the Commonwealth of Massachusetts Department of Public Health;

l. 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;

m. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any member, person experiencing homelessness, Enrollees with Special Health Care Needs, including individuals with disabilities, or other special populations served by the Contractor, by, at a minimum, having the capacity to, when necessary, communicate with Enrollees in languages other than English, communicate with individuals who are deaf, hard-of-hearing, or deaf blind, and making materials and information available in Alternative Formats as specified in this Contract;

n. The Contractor shall ensure that its Network Providers and Material Subcontractors meet all current and future state and federal eligibility criteria, standard and ad hoc reporting requirements, and any other applicable rules and/or regulations related to this Contract; and

o. As directed by EOHHS, the Contractor shall comply with any moratorium, numerical cap, or other limit on enrolling new Providers or suppliers imposed by EOHHS or the U.S. Department of Health and Human Services.

p. As further specified by EOHHS, the Contractor shall:

1) Include in its Provider Network the following state agency providers:

a) The providers set forth in **Appendix G, Exhibit 3** identified as providing inpatient behavioral health services as described in **Appendix C, Exhibit 3**, including inpatient mental health services; and

b) The providers set forth in **Appendix G, Exhibit 3** identified as providing Acute Treatment Services (ATS) and Clinical Support Services (CSS) as described in **Appendix C, Exhibit 3**.

2) Not require the state agency providers described in **Section 2.8.A.1.p.1** to indemnify the Contractor, to hold a license, or to maintain liability insurance; and

3) If required by EOHHS, include in its Provider Network or pay as out-of-network providers, other state agency providers as set forth in **Appendix G.**

q. Network PCP and Primary Care Practice PID/SL Modifications

1) The Contractor may request EOHHS' approval annually for changes to the Contractor's Network PCPs through the Accountable Care Organization Primary Care Provider Change Process, as further specified by EOHHS. If the change is approved, EOHHS shall add or remove the Network PCP for an effective date to be further specified by EOHHS. The Contractor shall provide supporting documentation, including from the PCP, as requested by EOHHS.

2) The Contractor may request EOHHS' approval annually for changes to the Tier Designation of Network Primary Care Practice PID/SLs, under the Primary Care Sub-Capitation Program described in **Section 2.23.A**, as further specified by EOHHS. If the change is approved, EOHHS shall update the Network Primary Care Practice PID/SLs' Tier Designation for an effective date to be further specified by EOHHS. The Contractor shall provide supporting documentation, including from the Network Primary Care Practice PID/SL, as requested by EOHHS

3) For new Enrollees enrolled pursuant to this Section, the Contractor shall develop policies and procedures to ensure uninterrupted care as described in **Section 2.4.F.4**.

4) The Contractor shall notify EOHHS of a Network PCP closure at least 60 days prior to the closing effective date. For certain Network PCP modifications, as further specified by EOHHS, the Contractor shall submit to EOHHS's Provider file maintenance process.

5) EOHHS shall provide the Contractor with specifications about the Accountable Care Organization Primary Care Provider Change Process, Provider file maintenance process, and Tier Designation change process. Such specifications may include when the Contractor shall use each process depending on a number of factors, including but not limited to any association between a proposed PCP's or Primary Care Practice

PID/SL's Taxpayer Identification Number (TIN) and either the Contractor's TIN or an existing PCP's or Primary Care Practice PID/SL's TIN.

2. Out-of-Network Access

The Contractor shall maintain and utilize protocols to address situations when the Provider Network is unable to provide an Enrollee with appropriate access to ACO Covered Services or medical diagnostic equipment due to lack of a qualified Network Provider or medical diagnostic equipment within reasonable travel time of the Enrollee's residence as defined in **Section 2.10.C**. The Contractor's protocols shall ensure, at a minimum, the following:

a. If the Contractor is unable to provide a particular ACO Covered Service or medical diagnostic equipment through its Provider Network, it will be adequately covered in a timely way out-of-network;

b. When accessing an out-of-network provider, the Enrollee is able to obtain the same service or to access a provider with the same type of training, experience, and specialization as within the Provider Network;

c. That out-of-network providers shall coordinate with the Contractor with respect to payment, ensuring that the cost to the Enrollee is no greater than it would be if the services were furnished through the Provider Network;

d. That the particular service will be provided by the most qualified and clinically appropriate provider available;

e. That the provider will be located within the shortest travel time of the Enrollee's residence, taking into account the availability of public transportation to the location;

f. That the provider will be informed of their obligations under state or federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Enrollee in their primary language;

g. That the only Provider available to the Enrollee in the Provider Network does not, because of moral or religious objections, decline to provide the service the Enrollee seeks;

h. That consideration is given for an out-of-network option in instances in which the Enrollee's Provider(s) determines that the Enrollee needs a service and that the Enrollee would be subjected to unnecessary risk if the Enrollee received those services separately and not all of the related services are available within the Provider Network; and

i. That the Contractor cover services furnished in another state in accordance with 42 CFR 431.52(b) and 130 CMR 450.109;

j. That the Contractor complies with **Section 2.8.F**

3. Additional Provider Network Requirements for Behavioral Health Services

The Contractor shall:

a. Ensure that its Behavioral Health Provider Network includes an adequate number of Providers with experience and expertise in various specialty populations. In addition to ensuring its Network includes Behavioral Health Providers who can address all Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM 5) (or current version as applicable) diagnostic needs as described in the most recent publication, the Contractor shall ensure that its Behavioral Health Provider Network has expertise in the following specialty populations and conditions:

1) Co-Occurring Disorders;

2) Serious and persistent mental Illness;

3) Children and adolescents, including children and adolescents with Serious Emotional Disturbance and Autism Spectrum Disorder;

4) Physical disabilities and chronic illness;

5) Deaf and hard of hearing and blind or visually impaired;

6) HIV/AIDS;

7) Homelessness;

8) Child Welfare and juvenile justice;

9) Fire-setting behaviors;

10) Sex-offending behaviors;

11) Post-adoption issues; and

12) Substance use disorders;

b. Allow independently practicing clinicians with the following licenses to apply to become Network Providers: Licensed Independent Clinical Social Worker (LICSW), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC) and

Licensed Psychologist;

c. Permit Enrollees to self-refer to any Network Provider of their choice for Medically Necessary Behavioral Health Services and to change Behavioral Health Providers at any time;

d. Require all Providers to provide an Enrollee's clinical information to other Providers, as necessary, to ensure proper coordination and behavioral health treatment of Enrollees who express suicidal or homicidal ideation or intent, consistent with state law;

e. For Behavioral Health Inpatient and 24-hour Diversionary Services:

1) Ensure that all Behavioral Health Inpatient and 24-Hour Diversionary Services Provider Contracts require the Behavioral Health Inpatient and 24-Hour Diversionary Services Provider accept for admission or treatment all Enrollees for whom the Contractor has determined admission or treatment is Medically Necessary, regardless of clinical presentation, as long as a bed is available in an age appropriate unit;

2) Promote continuity of care for Enrollees who are readmitted to Behavioral Health Inpatient and 24-Hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility;

3) Require Behavioral Health Inpatient and 24-Hour Diversionary Services Providers to coordinate treatment and Discharge Planning with the state agencies (e.g., DCF, DMH, DYS, DDS) with which the Enrollee has an affiliation;

4) Ensure that all Behavioral Health Inpatient and 24-Hour Diversionary Services Providers have:

a) Human rights and restraint and seclusion protocols that are consistent with the DMH's Human Rights and Restraint Seclusion Policy and regulations and include training of the Provider's staff and education for Enrollees regarding human rights;

b) A human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to Enrollees regarding their human rights, in accordance with **Appendix G** with applicable DMH regulations and requirements;

5) Require that Behavioral Health Inpatient and 24-hour Diversionary Services Providers coordinate with contracted CBHCs in the Contractor's Service Area(s), including procedures to credential and grant admitting

privileges to AMCI/YMCI Provider psychiatrists, if necessary; and

a) As needed, participate in or convene regular meetings and conduct ad hoc communication on clinical and administrative issues with CBHCs to enhance the continuity of care for Enrollees;

6) Include, in its Provider Network, Community-Based Acute Treatment Providers with the clinical expertise to provide specialized CBAT services to youth with ASD/IDD as described in **Appendix C** and as directed by EOHHS. The Contractor shall pay such Providers in accordance with **Section 2.8.D.7**.

f. As directed by EOHHS, contract with the network of Community Services Agencies (CSAs) in the Contractor's Service Area(s) to provide Intensive Care Coordination and Family Support and Training Services to MassHealth Standard and CommonHealth Enrollees. For each of these services, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 352, unless otherwise directed by EOHHS, and shall, use procedure codes as directed by EOHHS to provide payment for such services. As directed by EOHHS, the Contractor shall pay certain CSAs identified by EOHHS a daily case rate specified by EOHHS.

g. As directed by EOHHS, contract with a network of Providers to provide the following services, when Medically Necessary, to the specific groups of Enrollees indicated below:

1) Family Support and Training Services, to MassHealth Standard and CommonHealth Enrollees;

2) In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services, to MassHealth Standard and CommonHealth Enrollees; and

3) In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support), to all Enrollees under age 21.

h. For each of the services listed in **Section 2.8.A.3.g**, establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 352, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

i. As directed by EOHHS, contract with a network of Community Behavioral Health Centers in the Contractor's Service Area(s) to provide certain Behavioral Health Services. For services provided by CBHCs, the Contractor shall establish Provider

rates at or above the rate specified by EOHHS and shall pay in a manner as directed EOHHS, including but not limited to using bundled payments.

j. Behavioral Health Emergency Screening, Community Behavioral Health Centers (CBHCs), and Adult and Youth Mobile Crisis Intervention Services

1) CBHC Contracts

The Contractor shall:

a) Execute and maintain contracts with the CBHCs identified in **Appendix G, Exhibit 1** of this Contract, as updated by EOHHS from time to time, to provide all CBHC services, including Behavioral Health AMCI/YMCI services as set forth in **Appendix C**, as applicable, to this Contract;

b) Implement performance specifications specified by EOHHS, and ensure compliance with such specifications;

c) Not require CBHCs to obtain prior authorization for any services provided by CBHCs;

d) Provide payment for services provided by such CBHCs to Enrollees; and

e) As directed by EOHHS, take all steps and perform all activities necessary to execute contracts with CBHCs and support the successful implementation and operations of the CBHC program, including, without limitation, participation in meetings and workgroups, the development and implementation of new policies, and any other tasks as directed by EOHHS .

2) The Contractor shall establish Provider rates at or above the rate floor specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services

3) Enrollee Access to Behavioral Health AMCI/YMCI Provided by CBHCs

The Contractor shall:

a) Establish policies and procedures to make best efforts to ensure that all Enrollees receive AMCI or YMCI provided by a CBHC or hospital ED-based crisis evaluation services prior to hospital admissions for Inpatient Mental Health Services to ensure that Enrollees have been evaluated for diversion or referral to the least restrictive appropriate treatment setting.

b) Permit Enrollees access to Behavioral Health Services provided by CBHCs through direct self-referral, the BH Help Line, the Contractor's toll-free telephone line, or referral by family members or guardians, individual practitioners, PCPs, or community agencies or hospital emergency departments;

c) Require that the response time for face-to-face crisis evaluations by CBHCs does not exceed one hour from notification by telephone from the referring party or from the time of presentation by the Enrollee; and

d) Have policies and procedures to monitor Enrollee access to CBHCs and, as requested by EOHHS and in accordance with **Appendix A**, report, in a form and format as specified by EOHHS, about such access.

e) If needed, authorize Medically Necessary BH Covered Services within 24 hours following a AMCI or YMCI encounter.

4) CBHC Policies and Procedures

The Contractor shall:

a) In coordination with EOHHS' reporting and oversight, have policies and procedures to monitor CBHCs' performance with respect to established diversion and inpatient admission rates;

b) Have policies and procedures to monitor the CBHCs' performance with respect to diverting encounters with Enrollees from hospital emergency departments to the CBHCs' community-based locations or other community settings;

c) At the direction of EOHHS, identify and implement strategies to maximize utilization of community-based diversion services and reduce unnecessary psychiatric hospitalization, in a manner that is consistent with Medical Necessity criteria. Such strategies shall support Providers in shifting utilization from hospital EDs to community-based settings;

d) Have policies and procedures regarding the circumstances under which CBHCs shall contact the Contractor for assistance in securing an inpatient or 24-Hour Diversionary Service placement. Such policies and procedures shall include that if a CBHC requests the Contractor's assistance in locating a facility that has the capacity to timely admit the Enrollee, the Contractor shall contact Network Providers to identify such a

facility or, if no appropriate Network Provider has such capacity, shall contact out-of-network Providers to identify such a facility;

e) At the direction of EOHHS, participate in development of policies and procedures to ensure collaboration between CBHCs, Youth Mobile Crisis Intervention teams, Community Service Agencies (CSAs), Network Providers, BH CPs, DMH area and site offices, DCF regional offices, and DYS regional offices in the geographic area they serve;

f) Have a plan in place to direct Enrollees to the least intensive but clinically appropriate service;

g) Have a process to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available;

h) Utilize standardized documents such as risk management/safety plans as identified by EOHHS;

i) Convene meetings to address clinical and administrative issues with CBHCs and to enhance the coordination of care for Enrollees;

j) Attend statewide meetings regarding CBHCs and services provided by CBHCs, as convened by EOHHS and/or EOHHS' Behavioral Health contractor;

k) Ensure that contracted CBHCs utilize, as is necessary, the statewide Massachusetts Behavioral Health Access website or other required tracking method;

l) Ensure that, upon request of a court clinician conducting a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e):

(i) CBHCs provide Crisis Assessment and Intervention to Enrollees, identify to the court clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions; and

(ii) If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), and the CBHC determines that such admission is Medically Necessary, the CBHC conducts a search for an available bed, making best efforts to locate such a bed for the individual by 4:00

p.m. on the day of the issuance of such commitment order.

k. Medication for Opioid Use Disorder (MOUD) Services

1) The Contractor shall ensure that Enrollees have access to MOUD Services, including initiation and continuation of MOUD, and ensure that Enrollees receive assistance in accessing such services.

2) The Contractor shall include in its Provider Network, qualified Providers to deliver MOUD Services, by at a minimum, as further directed by EOHHS, and in accordance with all other applicable Contract requirements, offering Network Provider agreements at a reasonable rate of payment to:

a) All Office Based Opioid Treatment (OBOT) providers as specified by EOHHS;

b) All Opioid Treatment Program (OTP) providers as specified by EOHHS;

3) The Contractor shall ensure that all such Providers of MOUD Services coordinate and integrate care with Enrollees' PCPs and other Providers in response to Enrollees' needs;

4) As further directed by EOHHS, the Contractor shall ensure Enrollees may receive MOUD Services through qualified PCPs in the Provider Network;

5) The Contractor shall not require an authorization or referral for MOUD Services, unless otherwise directed by EOHHS.

l. As further specified by EOHHS, execute and maintain contracts with Restoration Centers, including:

1) Paying for ACO Covered Services delivered to Enrollees at Restoration Centers; and

2) Taking all steps and performing all activities necessary to maintain contracts with Restoration Centers, including but not limited to, participating in meetings and workgroups, developing and implanting policies and procedures, and completing any other tasks as further directed by EOHHS.

B. Provider Contracts

1. General

The Contractor shall:

a. Maintain all Provider Contracts and other agreements and subcontracts relating to this Contract, including agreements with out-of-network providers, in writing. All such agreements and subcontracts shall fulfill all applicable requirements of 42 CFR Part 438 and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity. Without limiting the generality of the foregoing, the Contractor shall ensure that all Provider Contracts and contracts with out-of-network providers include the following provision: "Providers shall not seek or accept payment from any Enrollee for any ACO Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any ACO Covered Service rendered to an Enrollee. Instead, Providers shall look solely to the (Contractor's name) for payment with respect to ACO Covered Services rendered to Enrollees. Furthermore, Providers shall not maintain any action at law or in equity against any Enrollee or EOHHS to collect any sums that are owed by the (Contractor's name) under the Contract for any reason, even in the event that the (Contractor's name) fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where "Contract" refers to the agreement between the Contractor and any Network Providers and non-Network Providers)." The Provider Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

b. Actively monitor the quality of care provided to Enrollees under any Provider Contracts and any other subcontracts;

c. Educate Providers through a variety of means including, but not limited to, Provider Alerts or similar written issuances, about their legal obligations under state and federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to the prior review and approval of EOHHS;

d. Require a National Provider Identifier on all claims and provider applications;

e. Not include in its Provider Contracts any provision that directly prohibits or indirectly, through incentives or other means, limits or discourages Network Providers from participating as Network or non-network Providers in any provider network other than the Contractor's Provider Network(s), except for the Contractor's Provider Contracts with Network PCPs, which shall include the provisions specified in **Section 2.7.C.1**; and

f. With respect to all Provider Contracts, comply with 42 CFR 438.214, including complying with any additional requirements as specified by EOHHS;

2. Additional Standards for Provider Contracts and Other Agreements with Providers

The Contractor shall maintain contracts in writing (Provider Contracts) with all Network Providers as follows:

a. All such Provider Contracts and agreements, including single case agreements, with out-of-network providers shall:

1) be in writing;

2) contain, at a minimum, the provisions described in this **Section**; and

3) comply with all applicable provisions of this Contract;

b. The Contractor shall not acquire established networks without executing a Provider Contract with each Provider that complies with all of the provisions of this **Section 2.7.B**., and any other applicable provisions of this Contract, and contacting each Provider to ensure that the Provider understands the requirements of this Contract and agrees to fulfill all terms of the Provider Contract. In Provider organizations where the organization represents the Provider in business decisions (e.g., a medical group or health center), a Provider Contract with the Provider organization shall be sufficient to satisfy this requirement. EOHHS reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to Network Providers, the existence of a contract between the Contractor and each individual Provider in the Provider Network;

c. The Contractor shall ensure that all Provider Contracts prohibit Providers, including but not limited to PCPs, from:

1) Billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments. Such Provider Contracts shall require Providers to work with Enrollees and the Contractor to assist Enrollees in keeping their appointments;

2) Billing patients for charges for ACO or Non-ACO Covered Services other than pharmacy co-payments;

3) Refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a Member;

4) Closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees.

d. The Contractor shall ensure that all Provider Contracts specify that:

1) No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition as described in **Section 1**;

2) As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 CFR 447.26(d) and as may be specified by the Contractor. The Provider shall comply with such reporting requirements to the extent the Provider directly furnishes services;

3) The Contractor shall not refuse to contract with or pay an otherwise eligible health care Provider for the provision of ACO Covered Services solely because such Provider has in good faith:

   a) Communicated with or advocated on behalf of one or more of their prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such Provider's patients; or

   b) Communicated with one or more of their prospective, current or former patients with respect to the method by which such Provider is compensated by the Contractor for services provided to the patient;

4) No contract between the Contractor and a Provider may contain any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay or limit specific, Medically Necessary Services, as described in **Section 2.8.D** and further specified by EOHHS;

5) A Provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions;

6) Neither the Contractor nor the Provider has the right to terminate the contract without cause and shall require the Provider to provide at least 60 days' notice to the Contractor and assist with transitioning Enrollees to new Providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee;

7) The Contractor shall provide a written statement to a Provider of the reason or reasons for termination with cause;

8) The Contractor shall notify Providers in writing of modifications in

payments, modifications in covered services or modifications in the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Contractor and the Provider or unless such change is mandated by the state or federal government without 30 days prior notice; and

9) Providers shall participate in Contractor's continuity of care policies and procedures as described in **Section 2.4.F**;

e. The Contractor shall not enter into a new contract, revise the risk arrangements in an existing contract, or revise the fee schedule in an existing contract with a Provider that is a physician or physician group which imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:

1) Stop-loss protection;

2) Minimum patient population size for the physician or physician group; and

3) Identification of the health care services for which the physician or physician group is at risk.

f. Contracts between the Contractor and Providers shall require Providers to comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services;

g. Contracts between the Contractor and Providers shall require Providers to participate, as further directed by EOHHS, in any EOHHS efforts or initiatives as described in **Section 2.3.B.5**; and

h. Nothing in this **Section** shall be construed to restrict or limit the rights of the Contractor to include as Providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers;

C. Additional Responsibilities for Certain Providers

1. Primary Care Providers (PCPs)

The Contractor shall ensure contracts with each PCP:

a. Require the PCP to:

1) Participate in the Primary Care Sub-Capitation Program, as described in **Section 2.23.A**;

2) Share clinical data on Enrollees with the Contractor, including but not limited to data to support the Quality Measure reporting requirements described in **Appendix Q**, and data to support the Health Equity Incentive Arrangement, as described in **Section 2.21.F** and **Appendix Q**, subject to all applicable laws and regulations, as further specified by EOHHS;

3) Observe and comply with all applicable member rights and protections in this Contract;

4) Provide care to Enrollees in accordance with the requirements described in **Section 2.5**, and otherwise assist the Contractor with meeting the requirements of this Contract, including documenting information in an Enrollee's medical record;

5) Perform, at a minimum, the following activities:

a) Supervising, coordinating and providing care to each assigned Enrollee;

b) For children and adolescents under 21, providing services according to the EPSDT Periodicity Schedule, including the administration of behavioral health screenings in accordance with **Section 2.8.C.3**;

c) Initiating referrals for Medically Necessary specialty care for which the Contractor requires referrals. The Contractor shall require its PCPs to refer Enrollees to Network Providers or, if the PCP refers the Enrollee to an out-of-network provider, to confirm with the Contractor that the Contractor will cover the Enrollee seeing that out-of-network provider and also inform the Enrollee to speak with the Contractor before seeing that out-of-network provider;

d) Ensuring that Enrollees who are identified as requiring Behavioral Health Services are offered referrals for Behavioral Health Services, when clinically appropriate;

e) Maintaining continuity of care for each assigned Enrollee; and

f) Maintaining the Enrollee's medical record, including documentation of all services provided to the Enrollee by the PCP, as well as any specialty services provided to the Enrollee;

6) Perform Enrollee screenings as follows:

a) Screen all MassHealth Standard and CommonHealth Enrollees under age 21 according to the EPSDT Periodicity Schedule and 130 CMR 450.140-149;

b) Screen all MassHealth Family Assistance Enrollees under age 21 according to the EPSDT Periodicity Schedule and 130 CMR 450.150;

c) Provide or refer all MassHealth Standard and CommonHealth Enrollees under age 21 for Medically Necessary treatment services in accordance with EPSDT requirements;

d) Provide or refer all MassHealth Family Assistance Enrollees under age 21 for Medically Necessary treatment services included in their benefit package;

e) For Enrollees under 21, require PCPs to use the standardized Behavioral Health screening tools described in the EPSDT Periodicity Schedule when conducting Behavioral Health screenings according to the EPSDT Periodicity Schedule and 130 CMR 450.140-150. The Contractor shall submit a report to EOHHS, in the form, frequency, and format found in **Appendix A**, documenting the number of behavioral health screenings provided to Enrollees during the quarter; and

f) The Contractor shall establish discrete rates for behavioral health screenings and shall use the same procedure codes as used by EOHHS to provide payment for such screenings.

b. Require that the PCP shall not contract as a:

1) Participating PCP with any entity, except the Contractor, that is participating as part of the MassHealth ACO Program;

2) PCP for an entity serving as an MCO, except when such PCP is serving a Special Kids Special Care (SKSC) Program enrollee; or

3) Primary Care Clinician (PCC) within MassHealth's PCC Plan.

c. Have a term of a minimum of one year from the Contract Operational Start Date; and

d. May only be terminated for cause.

2. The Contractor shall ensure that each PCP or group of PCPs is financially accountable to some degree for the Contractor's total cost of care (TCOC) performance and quality performance under this Contract and for the PCP's or group's contribution to that performance, with potential for the PCP or group to share gains from savings or share financial responsibility for losses, such that PCPs or groups of PCPs experience a meaningful portion of their annual Medicaid patient service revenue opportunity being tied to value-based performance measures.

   a. The Contractor shall report to EOHHS on the methodology and payments under such arrangement(s) in accordance with **Appendix A**.

   b. As further specified by EOHHS , the Contractor shall comply with any further guidance on parameters and requirements for such arrangements.

   c. Such accountability shall include performance measurement and management activities such as but not limited to the Contractor:

      1) Regularly evaluating each PCP's performance on costs of care, Quality Measures, or related measures of performance under this Contract, and performing practice pattern variation analysis to identify opportunities for individual PCPs to improve;

      2) Transparently reporting to each PCP the performance of the PCP on such measures;

      3) Identifying PCPs with unsatisfactory performance or opportunities to improve performance on the Contractor's identified measures, and implementing a performance improvement plan for such PCPs; and

      4) Adjusting alternative payment methodologies based on PCPs' performance to provide financial incentives for improved performance;

   d. In addition to implementing the Primary Care Sub-Capitation Program, the Contractor may develop, implement, and maintain other alternative payment methodologies for PCPs and/or Primary Care Practice PID/SLs. Such alternative payment methodologies may be for individual network PCPs or for practices, pods, or other groupings of network PCPs. Such alternative payment methodologies shall:

      1) Be subject to review by EOHHS;

      2) Be implemented in accordance with any guidance or requirements issued by EOHHS; and

3) Shift financial incentives away from volume-based, fee-for-service delivery for PCPs.

e. The Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty services provided to assigned Enrollees by specialty physicians; and

f. The Contractor shall maintain an adequate network of PCPs such that no individual PCP carries a panel that includes more than fifteen hundred (1500) Enrollees at any point in time, provided that

1) The Contractor may request prior written approval from EOHHS to temporarily waive this maximum. Such approval shall be granted at the sole discretion of EOHHS;

2) The Contractor shall report to EOHHS on its ratio of Enrollees to PCPs, in accordance with **Appendix A**;

3) The Contractor shall report to EOHHS on each PCP's total patients across payers, in accordance with **Appendix A**.

3. Behavioral Health Providers

The Contractor shall enter into and oversee Provider Contracts with Network Providers who provide Behavioral Health Services as follows:

a. The Contractor shall ensure that such Provider Contracts shall require that clinicians, including psychiatrists, psychiatric residents, psychiatric advanced practice registered nurses, psychologists, Licensed Independent Clinical Social Workers (LICSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), and unlicensed Master's level clinicians working under the supervision of a licensed clinician, who provide Behavioral Health Services to Enrollees under the age of 21 in certain levels of care, including Diagnostic Evaluation for Outpatient Therapy (individual Counseling, Group Counseling, and Couples/Family Counseling), In-Home Therapy, Inpatient Psychiatric Services, and Community Based Acute Treatment Services:

1) Participate in CANS training sponsored by EOHHS;

2) Become certified in the use of the CANS Tool and recertified every two years;

3) Use the CANS Tool whenever they deliver a Behavioral Health Clinical

Assessment for an Enrollee under the age of 21, including the initial Behavioral Health Clinical Assessment and, at a minimum, every 90 days thereafter during ongoing treatment;

4) Use the CANS Tool as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services; and

5) Subject to consent by the Enrollee, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT system the information gathered using the CANS Tool and the determination whether or not the assessed Enrollee is suffering from a Serious Emotional Disturbance (SED);

b. The Contractor shall ensure that such Provider Contracts with Community Service Agencies require that intensive care coordinators of all levels:

1) Become certified in the use of the CANS Tool and re-certified every two years;

2) Use the CANS Tool during the comprehensive home-based assessment that is part of the initial phase of Intensive Care Coordination (ICC), at least every 90 days thereafter during ongoing care coordination, and as part of Discharge Planning from ICC services; and

3) Subject to consent by the Enrollee, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT System the information gathered using the CANS Tool and a determination as to whether or not the Enrollee meets the definition of an SED;

c. The Contractor shall ensure that such Provider Contracts require all Behavioral Health Providers who have clinicians who are required to provide Behavioral Health Clinical Assessments and perform the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services using the CANS Tool in accordance with **Section 2.8.C.3.a**. above, have Virtual Gateway accounts and a high speed internet or satellite internet connection to access the CANS IT System, provided that the Contractor may have policies and procedures approved by EOHHS to grant temporary waivers for these requirements on a case by case basis;

d. The Contractor shall ensure that such Provider Contracts require Behavioral Health Providers to submit to the Contractor a written report of all Reportable Adverse Incidents in accordance with **Appendix A**, or in another form and format acceptable to EOHHS;

e. The Contractor shall establish policies and procedures that:

1) Pay EOHHS approved rates for CPT code 90791 with modifier HA for initial Behavioral Health Clinical Assessments using the CANS Tool for Enrollees under the age of 21 that are at least $15.00 more than the Contractor's rates for CPT code 90791 without modifier HA. The Contractor shall ensure that any failure to include an "HA" modifier using CPT Service Code 90791 will result in a denial of the claim for Enrollees under the age of 21, if billed without the HA modifier. For Enrollees under the age of 21, the Contractor shall allow Network Providers up to two 90791 "HA" claims per Enrollee per site in a 90-day period. The Contractor shall also allow a new set of 90791 "HA" claims when the Enrollee experiences a lapse in service of six months or more with the original provider;

2) Require Behavioral Health Network Providers who obtain such Enrollee consent to enter the information gathered using the CANS Tool and the determination whether or not the assessed Enrollee is suffering from an SED into the CANS IT System; and

3) Require Behavioral Health Network Providers who do not obtain such Enrollee consent to enter only the determination whether or not the assessed Enrollee is suffering from an SED into the CANS IT System.

f. As directed by EOHHS, the Contractor shall:

1) Only pay a Provider for providing Behavioral Health Clinical Assessments using the CANS Tool if such Provider's servicing clinicians are certified in the CANS Tool;

2) Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments and do not bill as a separately billable service the review and updating of the assessment that is required every 90 days for Enrollees in ongoing, individual, group, or family therapy since such review and updating is part of treatment planning and documentation; and

3) Ensure that its Providers have the ability to access and use the CANS IT System and data contained therein, and shall, as further directed by EOHHS, participate in any testing or development processes as necessary for EOHHS to build the CANS IT System.

g. As further specified by EOHHS, the Contractor shall develop and implement an alternative payment methodology strategy with its behavioral health Network Providers focused on increasing its use of alternative payment methodologies aimed at incentivizing Providers to improve performance, resulting in enhanced experience of care for Enrollees and improved outcomes.

h. The Contractor shall identify BH Network Providers included in the Contractor's Provider Directory who have not submitted at least two claims for BH Covered Services to Enrollees in the past 12 months, and report on such Providers to EOHHS as specified in **Appendix A**. EOHHS may require the Contractor to determine if Enrollees have meaningful access to these Providers, and if such Providers should remain in the Contractor's Provider Directory.

4. Network Hospitals

a. The Contractor shall develop, implement, and maintain protocols with each Network hospital that support the coordination of Enrollees' care, as part of the Contractor's Transitional Care Management program as described in **Section 2.5.F.1**.

b. The Contractor shall ensure that any agreement the Contractor holds with a hospital includes, at a minimum, the following requirements:

1) Emergency Department (ED) Services

a) The hospital shall notify the Enrollee's PCP, CP, ACO Care Management program, and/or Care Team within one business day of the Enrollee's presentation at a hospital's ED. Notification may include a secure electronic notification of the visit.

b) The hospital shall offer ED-based Behavioral Health crisis evaluation services to all members presenting with a behavioral health crisis in the ED.

c) The hospital shall offer substance use evaluations, treatment, and notification in the ED in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.

2) Notification of Inpatient Admission and Discharge Planning Activities

a) The hospital shall notify the Enrollee's PCP, CP, ACO Care Management program, and/or Care Team within one business day of the Enrollee's inpatient admission. Notification may include a secure electronic notification of the visit. EOHHS may specify the form and format for such notification.

b) The hospital, when possible, shall begin Discharge Planning on the first day of the Enrollee's inpatient admission.

c) In addition to satisfying all other requirements for Discharge Planning:

(i) The hospital shall ensure that the hospital's discharge summary is sent to the Enrollee's PCP, CP, ACO Care Management program, and/or Care Team within two business days of the discharge. The discharge summary shall include a copy of the hospital's discharge instructions that were provided to the Enrollee and include details on the Enrollee's diagnosis and treatment.

(ii) The hospital shall notify the Enrollee's PCP and the Contractor in order to ensure that appropriate parties are included in Discharge Planning. Such parties may include case managers, caregivers, and other critical supports for the Enrollee.

d) The hospital shall document in the Enrollee's medical record all actions taken to satisfy the notification and Discharge Planning requirements set forth in this **Section 2.8.C.4.b.**

3) A hospital with a DMH-licensed inpatient psychiatric unit shall accept into its DMH-licensed inpatient psychiatric unit all referrals of Enrollees that meet the established admission criteria of the inpatient unit.

4) The hospital shall report all available DMH-licensed beds into the Massachusetts Behavioral Health Access website at a minimum three times per day, 7 days per week. Such updates shall occur, at a minimum, between 8am-10am, 12pm-2pm, and 6pm-8pm, or at a time and frequency specified by EOHHS.

D. Provider Payments

The Contractor's payments to Network Providers shall be consistent with the provisions of this **Section**:

1. Timely Payment to Providers

The Contractor shall make payment on a timely basis to Providers for ACO Covered Services furnished to Enrollees, in accordance with 42 USC 1396u-2(f) and 42 CFR 447.46. Unless otherwise provided for and mutually agreed to in a contract between the Contractor and a Provider that has been reviewed and approved by EOHHS, the Contractor shall:

a. Pay 90% of all Clean Claims for ACO Covered Services from Providers within 30 days from the date the Contractor receives the Clean Claim;

b. Pay 99% of all Clean Claims from Providers within 60 days from the date the Contractor receives the Clean Claim;

c. Submit a Claims Processing report in accordance with **Appendix A**; and

d. For the purposes of this **Section**, the day the Contractor receives the Clean Claim is the date indicated by the date stamp on the claim and the day the Contractor pays the Clean Claim is the date of the check or other form of payment.

2. The Contractor shall not implement any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay or limit specific, Medically Necessary Services.

   a. The Provider shall not profit from provision of ACO Covered Services that are not Medically Necessary or medically appropriate.

   b. The Contractor shall not profit from denial or withholding of ACO Covered Services that are Medically Necessary or medically appropriate.

   c. Nothing in this **Section** shall be construed to prohibit Provider Contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph 5, below.

3. EOHHS may, in its discretion direct the Contractor to establish payment rates that are no greater than a certain percentage of the MassHealth Fee-For-Service (FFS) rate or another payment rate specified by EOHHS. Such maximum payment rate shall not be less than 100% of the MassHealth FFS rate. EOHHS may approve an exemption from any such requirement upon the Contractor's written request, which shall include the reason(s) why it is necessary for the Contractor to pay a higher rate, such as in order for the Contractor to implement alternative payment methodology. Nothing in this **Section** shall relieve the Contractor of its obligations to ensure access to ACO Covered Services in accordance with **Section 2.10** of this Contract.

4. Current Procedural Terminology Codes and Payment to Providers for Behavioral Health Services

   The Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for behavioral health services set forth in **Appendix C** as most recently adopted by the American Medical Association and CMS and shall pay no less than the MassHealth rate for such CPT codes;

5. The Contractor shall ensure Provider payments are consistent with the provisions set forth in **Sections 2.8.B.2.d.1 and 2.8.B.2.d.2**;

6. Payment Rates for Hospitals

a. The Contractor's Provider agreements with hospitals shall provide for payment equal to or less than 100% of MassHealth-equivalent rates under Sections 5.B.1 through 5.B.3, 5.B.6, 5.B.7, 5.C.1, and 5.D.7 of the MassHealth Acute Hospital Request For Application (RFA) (subject to Sections 8.2 and 8.3 of said RFA, as applicable), with the exception of Emergency and Post-Stabilization Services (which are governed by **Section 2.7.G** of this Contract) and Behavioral Health services. This maximum payment rate shall not apply if:

1) A higher rate is necessary for the Contractor to retain its ability to reasonably manage risk or necessary to accomplish the goals of this Contract (e.g., meet access and availability standards or an EOHHS-approved APM). The Contractor shall report any such Provider agreements to EOHHS for approval and explain the reason(s) such payments are necessary, in accordance with **Appendix A**;

2) The Provider agreement is with a specialty cancer hospital; or

3) The Provider agreement is a Provider agreement described in **Section 2.8.D.6.b** below.

b. Unless necessary for the circumstances described in **Section 2.8.D.6.a.1**, the Contractor's Provider agreement with a freestanding pediatric hospital for an inpatient discharge with a MassHealth DRG Weight of 3.0 or greater shall provide for payment equal to 100% of the MassHealth-equivalent rate described in **Section 2.8.D.6.a** above.

c. If the Contractor does not comply with this **Section 2.8.D.6**, with respect to its payments to hospitals, EOHHS may decrease the stop-loss payment made to the Contractor as described in **Sections 4.3B and 5.4.C**.

d. Notwithstanding **Sections 2.8.D.6.a and b**, the Contractor shall:

1) In accordance with **Section 2.8.D.6.d.2**, increase its payment rates to in-state acute hospitals for:

a) adjudicated inpatient discharges as determined by EOHHS by a uniform dollar amount specified by EOHHS; and

b) adjudicated outpatient episodes as determined by EOHHS by a uniform dollar amount specified by EOHHS.

2) The increased payment rates shall be uniform dollar amounts through lump sum payments as directed by EOHHS and consistent with the uniform dollar amount increase payment methodology set forth in Section 5.D.2 of the RFA. If directed by EOHHS, the Contractor shall pay in-state acute hospitals an additional uniform dollar amount based on the reconciliation set forth in **Section 4.3.C** by a date specified by

EOHHS.

7. Minimum Payment Rates for Certain Behavioral Health Services

a. For each Behavioral Health service listed in **Appendix O**, the Contractor shall not enter into Provider agreements that provide for payment below the rate specified by EOHHS in **Appendix O** for that service, unless **Section 2.8.F** requires a higher rate.

b. The Contractor shall provide specialized inpatient psychiatric services to Enrollees under the age of 21 with Autism Spectrum Disorder or Intellectual or Developmental Disability (ASD/IDD) in specialized ASD/IDD inpatient psychiatric treatment settings, as directed by EOHHS.

1) The Contractor shall report claims paid for psychiatric inpatient services delivered to Enrollees under the age of 21 in specialized ASD/IDD inpatient psychiatric treatment settings to EOHHS in a form and format and at a frequency to be determined by EOHHS;

2) The Contractor shall pay Providers no less than the rate specified by EOHHS for inpatient psychiatric services delivered to Enrollees under the age of 21 with ASD/IDD in specialized ASD/IDD inpatient psychiatric treatment settings;

c. For Case Consultation, Family Consultation, and Collateral Contact services delivered to Enrollees under the age of 21, the Contractor shall:

1) Establish a 15-minute rate at or above one quarter of the 60-minute rate the Contractor sets for Providers for outpatient Individual Treatment, or the amount set forth in **Appendix O,** whichever is higher; and

2) Revise procedure codes, service definitions, Medical Necessity criteria, and Authorization requirements for Case Consultation, Family Consultation, and Collateral Contact in consultation with and as directed by EOHHS.

d. For Acute Treatment Services for Substance Use Disorders (Level 3.7), including Individualized Treatment Services, the Contractor shall establish Provider rates at or above the rate floor as specified by EOHHS unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

e. For Clinical Support Services for Substance Use Disorders (Level 3.5), including Individualized Treatment Services, the Contractor shall establish Provider rates at or above the rate floor as specified by EOHHS unless otherwise directed by

EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

f. For Applied Behavioral Analysis (ABA Services), the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 358, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

g. For Residential Rehabilitation Services for Substance Use Disorders (ASAM Level 3.1) (RRS), including Adult RRS, Family RRS, Transitional Age Youth and Young Adult RRS, Youth RRS, and Co-Occurring Enhanced RRS, the Contractor shall establish Provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

h. For Program of Assertive Community Treatment services (PACT), the Contractor shall establish Provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

i. For the Behavioral Health Services described in **Section 2.8.A.3.f-i,** the Contractor shall establish Provider rates and use procedure codes as set forth in those Sections.

j. The Contractor's payment rates to inpatient psychiatric hospitals for Enrollees placed on AND status should be adequate to maintain the ongoing provision of appropriate clinical care until date of discharge.

k. For Behavioral Health screens specified by EOHHS, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 317, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

l. For inpatient mental health services, the Contractor shall establish Provider rates at or above 100% of the MassHealth-equivalent rates under Section 5.B.4 of the MassHealth Acute Hospital Request for Application and Section 4.2 of Attachment A to the MassHealth Psychiatric Hospital Request for Application, unless otherwise directed by EOHHS.

m. The Contractor shall pay a fifteen percent (15%) rate increase over the Contractor's negotiated rates starting on the effective date of the Contractor's Behavioral Health Urgent Care contract for the specified services provided at Mental Health Center locations in the Contractor's Network that are designated as Behavioral Health Urgent Care Provider sites. The Contractor is required to pay these rates by using the appropriate codes, as detailed in Table 1 of Managed Care Entity Bulletin 83, with the Urgent Care modifier, GJ. These codes

may be subject to modification or change as directed by EOHHS. EOHHS will inform the Contractor which MHCs have been designated as Behavioral Health Urgent Care Providers.

n. For inpatient substance use disorder services provided by freestanding substance use disorder hospitals, the Contractor shall establish provider rates at or above the rates under Section A of the MassHealth Substance Use Disorder Contract, unless otherwise directed by EOHHS.

o. For Structured Outpatient Addiction Program Services and Enhanced Structured Addiction Program Services, the Contractor shall establish Provider rates at or above the rate floor as set by EOHHS 101 CMR 306, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

p. For Opioid Treatment Program Services the Contractor shall establish Provider rates at or above the rate floor as specified by EOHHS in 101 CMR 444, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

8. Non-Payment and Reporting

a. Non-Payment and Reporting of Serious Reportable Events

1) The Contractor shall work collaboratively with EOHHS to develop and implement a process for ensuring non-payment or recovery of payment for services when "serious reportable events" (a/k/a "Never Events"), as defined by this Contract, occur. The Contractor's standards for non-payment or recovery of payment shall be, to the extent feasible, consistent with the minimum standards for non-payment for such events developed by EOHHS;

2) The Contractor shall notify EOHHS of SREs, in accordance with **Appendix A** and guidelines issued by the Department of Public Health (DPH); and

3) The Contractor shall provide, at a frequency and format specified by EOHHS, a summary of SREs in accordance with **Appendix A**. Such summary shall include the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE;

b. Non-Payment and Reporting of Provider Preventable Conditions

1) The Contractor shall take such action as is necessary in order for EOHHS to comply with and implement all federal and state laws, regulations, policy guidance, and MassHealth policies and procedures relating to the identification, reporting, and non-payment of provider preventable

conditions, including Section 2702 of the Patient Protection and Affordable Care Act and regulations promulgated thereunder;

2) In accordance with 42 CFR 438.3(g), the Contractor shall:

   a) As a condition of payment, comply with the requirements mandating Provider identification of Provider-Preventable Conditions, as well as the prohibition against payment for Provider-Preventable Conditions as set forth in 42 CFR 434.6(a)(12) and 447.26; and

   b) Report all identified Provider-Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Appendix A**;

3) The Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 CFR 434.6(a)(12), 42 CFR 438.3(g), and 42 CFR 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

   a) The Contractor shall not pay a Provider for a Provider Preventable Condition;

   b) The Contractor shall require, as a condition of payment from the Contractor, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by the Contractor and/or EOHHS;

   c) The Contractor shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee;

   d) A Contractor may limit reductions in Provider payments to the extent that the following apply:

      (i) The identified Provider-Preventable Condition would otherwise result in an increase in payment; and

      (ii) The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to

treatment for, and related to, the Provider-Preventable Condition;

e) The Contractor shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services;

c. Non-Payment and Reporting of Preventable Hospital Readmissions

As directed by EOHHS, the Contractor shall develop and implement a process for ensuring non-payment or recovery of payment for preventable hospital readmissions. Such process shall be, to the extent feasible, consistent with minimum standards and processes developed by EOHHS;

9. Fluoride Varnish

a. The Contractor shall provide additional reimbursement for the application of Fluoride Varnish by Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses), when provided to eligible MassHealth Members under age 21, during a pediatric preventive care visit where the service is Medically Necessary as determined by a Caries Assessment Tool (CAT);

b. In order to qualify for the additional reimbursement, the Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses) must be certified by either self-administering the American Academy of Pediatrics (AAP) Oral Health Group's online training on Cavity Risk Assessment at http://www.aap.org/commpeds/dochs/oralhealth/cme or the Smile for Life program at www.stfm.org/oralhealth; or attending an instructor-led training session at a time and location to be announced by EOHHS;

c. The Contractor shall require that all PCPs indicate to the Contractor, upon request, whether they are certified to provide Fluoride Varnish and to notify the Contractor of any change in their certification status; and

d. The Contractor shall instruct PCPs who are not certified to direct or refer their patients who need fluoride varnish to the Contractor for assistance in finding a certified Provider;

10. For COVID-19 vaccine administration, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 446, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

11. For the delivery of monoclonal antibody products, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 446 and 101 CMR

206.10(8), as applicable, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

12. For monkeypox vaccine administration and testing, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 317 and 320, respectively, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

E. Provider Directory and Other Information

1. Provider directory

The Contractor shall maintain a searchable Provider directory (or directories) as further specified by EOHHS. Such directory (or directories) shall include PCPs, Behavioral Health Providers, hospitals, specialists, sub-specialists, pharmacies, and ancillary service Providers, including a listing of statewide emergency rooms and Crisis Services providers, including CBHCs, that is made available in Prevalent Languages and Alternative Formats, upon request, and includes, at a minimum, the following information:

a. For PCPs, Behavioral Health Providers, hospitals, pharmacies, and specialists:

1) Alphabetical Provider list, including any specialty and group affiliation as appropriate;

2) Geographic list of Providers by town;

3) Office address and telephone numbers for each Provider, as well as website URL as appropriate;

4) Office hours for each Provider;

5) The Provider's Cultural and Linguistic Competence and capabilities, including languages spoken by Provider or by skilled medical interpreter at site, including ASL, and whether the Provider has completed cultural competence training;

6) Whether or not the Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment;

7) PCPs with open and closed panels, where open panel refers to those accepting any new patient, and closed panel refers to those that are limited to the current patients only; and

8) For Behavioral Health Providers, required information also includes qualifications and licensing information, and special experience, skills,

and training (i.e., trauma, child welfare, substance use);

b. For ancillary services Providers:

1) Alphabetical Provider list; and

2) Geographic list of Providers by town.

c. For pharmacies:

1) Alphabetical listing of the pharmacy chains included in the Contractor's network;

2) Alphabetical listing of independent pharmacies, including addresses and phone numbers;

3) Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line for assistance in finding a convenient pharmacy; and

4) The information in **Section 2.8.E.1.a** above.

2. The Contractor shall provide EOHHS with an updated electronic submission of its Provider directory (or directories) upon request, and on a semi-annual basis, if updated, and an electronic submission of changes to the Provider Network monthly.

3. The Contractor shall provide the Provider directory to its Enrollees as follows:

a. The Contractor shall provide a copy in paper form to Enrollees upon request. The Contractor shall update its paper-version of its Provider directory monthly if the Contractor does not have a mobile-enabled, electronic directory as further specified by EOHHS and quarterly if the Contractor has such mobile-enabled electronic directory as further specified by EOHHS;

b. The Contractor shall include written and oral offers of such Provider directory in its outreach and orientation sessions for New Enrollees; and

c. The Contractor shall include an electronic copy of its Provider directory on the Contractor's website in a machine-readable file and format. The Contractor shall update its electronic version of its Provider directory no later than 30 calendar days after being made aware of any change in information.

4. The Contractor shall provide to EOHHS, in accordance with **Appendix A** and as requested by EOHHS, an ad hoc report of all rates paid to a parent organization or a subsidiary in the previous Contract Year;

5. As requested by EOHHS, the Contractor shall, in a form and format specified by EOHHS,

report to EOHHS its Network Providers and whether each Provider is enrolled as a MassHealth Provider;

6. The Contractor shall develop, maintain and update information about Providers, including, but not limited to, PCPs and Behavioral Health Providers, with areas of special experience, skills, and training including, but not limited to, Providers with expertise in treating: children, adolescents, people with HIV, persons experiencing homelessness, people with disabilities, people with Autism Spectrum Disorder, people who are deaf or hard-of-hearing, people who are blind or visually impaired, and children in the care or custody of DCF or youth affiliated with DYS (either detained or committed. The Contractor shall make available to EOHHS, Members, and Enrollees, such information upon request.

7. The Contractor shall provide to an Enrollee directly, or through referral, publicly available information maintained by the Massachusetts Board of Registration in Medicine (BORIM) and the National Practitioner Databank on the malpractice history of any Provider(s), upon an Enrollee's request;

8. The Contractor shall demonstrate to EOHHS, by reporting in accordance with **Appendix A**, that all Providers within the Contractor's Provider Network are credentialed according to **Section 2.9.H**. of the Contract;

9. Provider Network Changes

    a. The Contractor shall provide notice to EOHHS of significant changes (additions or deletions) in the operations of the Provider Network and significant to the Provider Network itself, that will affect the adequacy and capacity of services. At the time of any change that (a) prevents the Contractor from complying with **Sections 2.8.A. and B**.; and (b) meets the requirements of **Section 2.8.F.2**. below, the Contractor shall provide immediate written notice to EOHHS, with the goal of providing notice to EOHHS at least 90 days prior to the effective date of any such change. Such notice shall be in the form and format specified by EOHHS and the Contractor shall provide EOHHS will all requested information about the significant change;

    b. Significant changes requiring notification include, but are not limited to, the following:

        1) Changes in the operations of the Provider Network that result from EOHHS changes in ACO Covered Services, and Provider or Material Subcontractor payment methodology;

        2) Enrollment of a new population in the Contractor's Plan;

        3) Any termination or non-renewal of a hospital, community health center or community mental health center contract;

4) Any termination or non-renewal of a PCP contract;

5) Any termination or non-renewal of a PCP, or changes in hours, access, or staffing that results in there being no other, or a limited number, of PCPs or PCP sites, available in a Service Area or part of a Service Area;

6) Any termination or non- renewal of a Behavioral Health Provider or specialist contract that results in there being no other, or a limited number of, Behavioral Health Providers or specialists available in a Service Area or part of a Service Area;

7) Obstetrics/Gynecology access in a Service Area or part of a Service Area that decreases below ratios specified in **Sections 2.10.B. and C**; or

8) Changes to pharmacy Network Providers.

c. The Contractor shall provide any information requested by EOHHS pertaining to any such significant change within seven calendar days of the request;

d. For PCP or Behavioral Health Provider Network significant changes, the Contractor shall notify EOHHS of the number of affected Enrollees, and the specific steps the Contractor is taking to assure that such Enrollees continue to have access to Medically Necessary Services;

e. For Pharmacy Provider Network significant changes, the Contractor shall notify EOHHS of the number of affected Enrollees and the specific steps the Contractor is taking to assure that such Enrollees continue to have access to Medically Necessary Services. This information should be provided to MassHealth at least 90-days in advance of the change.

f. The Contractor shall provide to EOHHS a written summary of all significant change(s) with its next Summary of Access and Availability report set forth in **Appendix A**, and in the timeframes specified in **Appendix A**, that describes the issues, the steps taken to date to assure that Enrollees have access to Medically Necessary services, and any relevant next steps; and

g. In the event that a Provider leaves or is terminated from the Contractor's Network, the Contractor shall follow the process set forth by EOHHS for communicating with and, as appropriate, transitioning Enrollees affected by the termination. Such process shall include developing a member communication and outreach plan and a provider communication and outreach plan, and performing other activities EOHHS determines necessary;

10. The Contractor shall report to EOHHS in accordance with **Appendix A** and as a component of the Summary of Access and Availability report set forth in **Appendix A**, all PCPs, including groups, health centers, and individual physician practices and sites,

which are not accepting new patients and have been granted the ability to do so by the Contractor;

F. FQHCs

The Contractor shall:

1. Ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 101 CMR 304.04, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

2. Institute certain policies to align with MassHealth's investment in FQHCs, as set forth in MassHealth Managed Care Entity Bulletins and other guidance, including but not limited to MassHealth implementing a new rate structure that includes an updated prospective payment system (PPS) rate methodology and MassHealth increasing rates as part of an alternative payment methodology (APM) that requires payment at or above the individual PPS rates. Specifically, the Contractor shall:

    a. Conform its coverage policies with respect to medication therapy management (MTM), collaborative drug therapy management (CDTM), behavioral health integration (BHI), and collaborative care management (CoCM) services to align with MassHealth's coverage policies as further specified by EOHHS;

    b. Require FQHCs to bill for services and visits specified by EOHHS using the codes specified by EOHHS;

    c. Pay claims submitted by FQHCs for the codes specified by EOHHS at a rate equal to or above the MassHealth fee-for-service (FFS) rate specified by EOHHS; provided, however, that for codes included in the Primary Care Sub-Capitation Program code set, the Contractor shall pay zero (0) dollars when the code is billed by a FQHC for an Enrollee attributed to the FQHC;

    d. Pay for out-of-network FQHC claims submitted by FQHCs for the codes set forth by EOHHS at a rate equal to or above the MassHealth FFS rate specified by EOHHS;

    e. Cooperate with EOHHS in EOHHS' review of the Contractor's Encounter Data to monitor compliance with these Contract requirements as further specified by EOHHS.

        1) If EOHHS determines that the Contractor did not pay at or above the MassHealth FFS rates as specified by EOHHS, the Contractor shall reconcile any discrepancy in paid amounts.

2) If the Contractor does not reconcile a discrepancy identified by EOHHS within a reasonable time as determined by EOHHS, EOHHS may impose an intermediate sanction as set forth in **Section 5.4**.

f. Provide, in the form and format specified by EOHHS, any information or data requested regarding claims and payments related to the codes for FQHC services and visits specified by EOHHS.

G. Vaccine Administration

The Contractor shall not pay more for vaccine administration than permitted under federal regulations, see Federal Register of October 3, 1994, RIN 0938-AG77 (Vaccine for Children Program).

H. Critical Access Hospitals

The Contractor shall ensure its payments to any licensed hospital facility operating in the Commonwealth that has been designated as a critical access hospital under 42 U.S.C. 1395i-4 are an amount equal to at least 101 percent of allowable costs under the Contractor's plan, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services.

Section 2.9 Network Management

A. General Requirements

The Contractor shall:

1. Develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, the principles of rehabilitation and recovery for Behavioral Health Services, Cultural and Linguistic Competence, and cost effectiveness. The management strategy shall address all Providers. Such strategy shall include at a minimum:

   a. A system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

   b. A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals; and

   c. Conducting on-site visits to Network Providers for quality management and quality improvement purposes;

2. Ensure that its Provider Network is adequate to assure access to all ACO Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the ACO Covered Services;

3. Ensure that Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this Contract;

4. Monitor and enforce access and other Network standards required by this Contract and take appropriate action with Providers whose performance is determined by the Contractor to be out of compliance;

5. Demonstrate, through reports specified in **Appendix A**, that it satisfies the following requirements. The Contractor shall submit such reports at the frequency specified in **Appendix A** and no less frequent than at the time it executes this Contract, on an annual basis, and at any time there is a significant change, as defined by EOHHS, in the Contractor's operations that would affect the adequacy of capacity and services.

    a. Offers an appropriate range of preventive/primary care and specialty services that is adequate for the anticipated number of Enrollees for its Service Area(s); and

    b. Maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in its Service Area(s), as defined in **Section 2.9.B**. below;

6. Operate a toll-free telephone line for Provider inquiries during normal business hours for a minimum of eight hours per day, Monday through Friday, and have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of Urgent or Emergency Services provided, however, that the Contractor and its Providers shall not require such verification prior to providing Emergency Services;

7. Maintain and distribute a Provider Manual(s), which includes specific information about ACO Covered Services, Non-ACO Covered Services, and other requirements of the Contract relevant to Provider responsibilities. The Contractor shall submit an updated Provider Manual(s) to EOHHS annually and such updated Provider Manual(s) shall be distributed to Providers annually and made available to Providers on the Contractor's website. The Provider Manual(s) shall include, but not be limited to, the following information:

    a. Enrollee rights, including those in **Section 5.1.L**, and the requirement that Enrollees must be allowed to exercise such rights without having their treatment adversely affected;

    b. Provider responsibilities, especially those that apply to Enrollee rights;

    c. That Enrollees may file a grievance with the Contractor if the Provider violates any Enrollee rights and the steps the Contractor may take to address any such grievances;

    d. Enrollee privacy matters;

e. Provider responsibility for assisting Enrollees with interpreter services;

f. Provider obligation to accept and treat all Enrollees regardless of race, ethnicity, English proficiency, gender, gender identity, religion, creed, sexual orientation, health status, or disability;

g. General rules of Provider-enrollee communications;

h. ACO Covered Services lists;

i. Provider obligation to make enrollees aware of available clinical care management options and all available care options;

j. An explanation to all Providers that in certain situations minors under the law may consent to medical procedures without parental consent;

k. Permissible Provider Marketing activities in accordance with **Section 2.12.B**;

l. That in addition to the general prohibitions against charging Enrollees in **Section 2.8.B** of this Contract, Providers may not charge Enrollees for any service that (a) is not a Medically Necessary ACO or Non-ACO Covered Service; (b) that there may be other ACO Covered Services or Non-ACO Covered Services that are available to meet the Enrollee's needs; and (c) where the Provider did not explain items (a) and (b) and (c), that the Enrollee will not be liable to pay the Provider for the provision of any such services. The Provider shall be required to document compliance with this provision;

m. Information on Advance Directives;

n. The Contractor's authority to audit the presence of Advance Directives in medical records;

o. Services that need PCP referrals or prior authorization;

p. Enrollee rights to access and correct medical records information;

q. The process through which the Contractor communicates updates to policies (for Providers and subcontractors);

r. Timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

s. The process and timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

t. Protocols for transitioning Enrollees from one Behavioral Health Provider to another;

u. Coordination between Behavioral Health Providers and PCPs;

v. Coordination between Behavioral Health Providers and state agencies, including but not limited to, DCF, DYS, DMH, DTA and local education authorities;

w. Provider responsibility for submission of Notification of Birth (NOB) forms;

x. Steps a Provider must take to request disenrollment of a Member from their panel;

y. Information on the Contractor's administrative appeals process; and

z. Information on the Contractor's process for an Internal Appeal following an Adverse Action, including an Enrollee's right to use a Provider as an Appeal Representative;

8. Maintain a protocol that shall facilitate communication to and from Providers and the Contractor, and which shall include, but not be limited to, a Provider newsletter and periodic Provider meetings;

9. Except as otherwise required or authorized by EOHHS or by operation of law, ensure that Providers receive 30 days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect;

10. Work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Goals and Quality Measures and all other requirements of this Contract;

11. Responsiveness to Provider Requests to Enter into Agreement with the Contractor

The Contractor shall develop and maintain, and provide to EOHHS for review, policies and procedures regarding its responsiveness to provider requests to enter into agreements with the Contractor to provide services to an Enrollee, including but not limited to Provider Agreements and single case agreements. Such policies and procedures shall include, but may not be limited to, how the Contractor:

a. Acknowledges receipt of the request, including whether such acknowledgement is in writing or in another manner; and

b. Provides a reasonable estimate as to the time it will take for the Contractor to make a decision with respect to such request, including whether such estimate takes into account the enrollee's health condition.

12. Enter into at least one alternative payment methodology contract with Providers, in addition to the value-based contract requirements laid out in **Section 2.8.C.1** and **Section 2.8.A.3.i**. Such arrangement(s) shall be reviewed by EOHHS.

B. Primary Care Provider (PCP) Network

1. The Contractor shall report to EOHHS, in accordance with **Appendix A**, the following:

   a. A geographic access report for adult PCPs and pediatric PCPs demonstrating access by geography; and

   b. A PCP-to-Enrollee ratio report showing open and closed adult PCPs and pediatric PCPs per number of Enrollees.

2. The Contractor shall make best efforts to ensure that PCP turnover does not exceed 7% annually. The Contractor shall monitor and annually report to EOHHS the number and rate of PCP turnover separately for those PCPs who leave the Contractor's Plan voluntarily and those PCPs who are terminated by the Contractor. If the Contractor's annual PCP turnover rate exceeds 7%, the Contractor shall submit an explanation for the turnover rate to EOHHS and shall propose a corrective action plan in accordance with **Section 5.4.H**. for EOHHS's review and approval.

3. In collaboration with, and as further directed by EOHHS, the Contractor shall develop and implement quality improvement activities directed at:

   a. Informing PCPs about the most effective use of the EOHHS-approved standardized behavioral health screening tools;

   b. How to evaluate behavioral health information gathered during screenings conducted by Network Providers, such as how to evaluate the results from a behavioral health screening tool;

   c. How and where to make referrals for follow-up behavioral health clinical assessments and services if such referrals are necessary in the judgment of the PCP;

   d. Assisting EOHHS to improve tracking of delivered screenings, positive screenings and utilization of services by PCPs or Behavioral Health Providers following a behavioral health screening; and

   e. Use of data collected to help delivery of EPSDT screenings, including assuring that PCPs offer behavioral health screenings according to the EPSDT Periodicity Schedule and more often as requested and Medically Necessary.

4. The Contractor shall provide education and training at least annually for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify Behavioral Health Service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate.

5. The Contractor shall submit a report to EOHHS, in the form and format found in

Appendix A, documenting the number of EPSDT behavioral health screenings provided to Enrollees. In accordance with the guidelines established by the Psychotropic Medications in Children Workgroup, the Contractor shall monitor and analyze the prescribing of psychiatric medications in children under the age of 19. Such monitoring and analyzing shall include:

a. Establishing policies and procedures to identify and monitor psychopharmacologic outlier prescribing patterns by PCPs and other prescribers; and

b. Establishing criteria, policies and procedures to offer review, consultation, support and Behavioral Health referral resources to the prescriber, as determined appropriate by the Contractor.

6. The Contractor shall monitor Enrollees' voluntary changes in PCPs to identify Enrollees with multiple and frequent changes in PCPs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long term patient-doctor relationship with one's PCP, and to recommend to the PCP that a screen for the need for any Behavioral Health Services may be indicated, including situations where the Contractor suspects drug seeking behavior.

7. The Contractor shall, at the direction of EOHHS, require its PCPs to complete practice surveys provided by EOHHS.

C. Behavioral Health Requirements

1. Substance Use Disorder Treatment Providers

a. To the extent permitted by law, the Contractor shall require all substance use disorder treatment Providers to submit to DPH/BSAS the data required by DPH.

b. The Contractor shall require all substance use disorder treatment Providers to track, by referral source:

1) All referrals for services;

2) The outcome of each referral (i.e., admission, etc.); and

3) If the substance use disorder treatment Provider refuses to accept a referral, the reason for the refusal, and alternative referrals made.

2. State-Operated Community Mental Health Centers (SOCMHCs)

The Contractor shall refer cases to the SOCMHCs in a manner that is consistent with the policies and procedures for Network referrals generally. See **Appendix G, Exhibit 2**, for a list of SOCMHCs, which may be updated by EOHHS from time to time.

3. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with

EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Children's Behavioral Health Initiative (CBHI) network. The Contractor shall:

a. Inform EOHHS in writing of authorization procedures for Behavioral Health Services for Enrollees under 21 who are receiving CBHI Services, and of any changes to such authorization procedures prior to their implementation. The Contractor shall assist Providers in learning how to utilize the Contractor's authorization procedures with respect to CBHI Services. The Contractor shall monitor its authorization procedures to ensure that the procedures provide for timely access to CBHI Services. In the event that the Contractor's authorizations procedures with respect to CBHI Services result in delays or barriers to accessing Medically Necessary services, the Contractor shall modify such authorization procedures;

b. Ensure that the authorization procedures established for ICC and Family Support and Training allow for at least the first 28 days to occur without prior approval. The Contractor may establish notification or registration procedures during the first 28 days of ICC;

c. Ensure that its authorization procedures comply with all provisions of **Section 2.7.C** of the Contract and, in addition, that all authorization approvals for ICC and Family Support and Training are provided at the time of the Provider request;

d. Ensure that ICC and Family Training and Support Services are delivered according to both the program specifications and the EOHHS-approved ICC Operations manual. In the event that there are discrepancies between the two documents, performance specifications shall control and the Contractor shall notify EOHHS of any discrepancies for correction;

e. Assign a single point of contact for management of the CBHI network. The Contractor's single point of contact's responsibilities shall include, but not be limited to, providing in person technical assistance to Providers who provide CBHI Services to answer questions regarding authorization of services and assisting Providers in facilitating and ensuring that the Providers engaged in a youth's treatment will participate in all care plan/treatment meetings;

f. Ensure that Providers' staff participate in CBHI training, coaching and mentoring provided by EOHHS's CBHI training vendor, including on-site activities, distance learning, and Quality Improvement activities recommended by the training vendor. The Contractor shall ensure that Providers' staff completes the CBHI training, coaching and mentoring tasks assigned by the training vendor, and utilizes their new skills in service delivery. If the Provider is not participating in the training vendor's activities, the Contractor shall engage in Provider Network

Management activities to increase participation;

g. Ensure that each CSA develops and coordinates a local systems of care committee to support each CSA's efforts to establish and sustain collaborative partnerships among families and community stakeholders in its geographic area. The Contractor shall assign a staff person who shall participate in the local systems of care committees as agreed to in collaboration with all MassHealth managed care entities and shall attend monthly meetings of the committees for the first year of the CSA implementation;

h. Ensure that Providers of CBHI Services provide each such service in accordance with all EOHHS approved CBHI Services performance specifications and CBHI Services Medical Necessity Criteria; and

i. Develop specific quality management activity plans for Providers of CBHI Services;

j. The Contractor shall make available the intensive hospital diversion (IHD) program, through its network of qualified In-Home Therapy providers, for youth up to age 21, as an alternative to 24-hour level of care. The program will support youth in crisis after the initial crisis evaluation and intervention has been rendered. The program shall provide intensive, short-term therapy to stabilize youth and their families with the goal of ameliorating the need for hospitalization and establishing community linkages such as Children's Behavioral Health Initiative (CBHI) services and other Behavioral Health services to maintain the youth in the community. The Contractor shall adopt the IHD performance specifications specified by EOHHS.

4. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Residential Rehabilitation Services for Substance Use Disorders (RRS) network. The Contractor shall:

a. As further directed by EOHHS and in accordance with all other applicable Contract requirements, contract with all qualified, licensed RRS providers willing to accept the rate specified by EOHHS;

b. The Contractor shall support each RRS Provider's efforts to establish and sustain collaborative partnerships among service Providers and community stakeholders in its geographic area;

c. Ensure that RRS is provided in accordance with EOHHS-approved RRS performance specifications and RRS Medical Necessity Criteria which shall align with the American Society for Addiction Medicine (ASAM) criteria;

d. Submit for EOHHS's approval authorization and concurrent review procedures

for RRS and any changes to such authorization and concurrent review procedures prior to their implementation. The Contractor shall:

1) Utilize the American Society for Addiction Medicine (ASAM) criteria as the basis for establishing authorization and concurrent review procedures;

2) Assist RRS Providers in learning how to utilize the Contractor's authorization and concurrent review procedures with respect to RRS;

3) Ensure that the authorization procedures established for RRS allow for at least the first 90 days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of RRS;

e. Assign a single point of contact for management of the RRS network. The Contractor's single point of contact's responsibilities shall include, but not be limited to, providing in- person technical assistance to RRS Providers to answer questions regarding billing and authorization of services and assisting RRS Providers in facilitating and ensuring that Enrollees are connected to other services as indicated by the Enrollees treatment plan; and

f. For RRS, establish Provider rates and use procedure codes as set forth in **Section 2.8.D.7**.

5. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing Recovery Coach services, as described in **Appendix C**. The Contractor shall:

a. As directed by EOHHS and in accordance with all other applicable Contract requirements, contract with all qualified providers seeking to join the Contractor's Provider Network to provide Recovery Coach services;

b. Ensure that Recovery Coach services are provided in accordance with all EOHHS approved Recovery Coach performance specifications and Recovery Coach Medical Necessity Criteria;

c. Adopt authorization, concurrent review, notification or registration procedures, and documentation parameters for Recovery Coaches in accordance with a uniform standard established by EOHHS. The Contractor shall:

1) Assist Providers in learning how to utilize the Contractor's authorization and concurrent review procedures with respect to Recovery Coach services;

2) Ensure that the authorization procedures established for Recovery Coach services allow for at least the first 60 days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 60 days of Recovery Coach services as specified by EOHHS;

d. For Recovery Coach services, establish Provider rates and use procedure codes as set forth in **Section 2.8.D.7**.

6. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Recovery Support Navigator network, as described in **Appendix C**. The Contractor shall:

a. As directed by EOHHS and in accordance with all other applicable Contract requirements, contract with all qualified providers seeking to join the Contractor's Provider Network to provide Recovery Support Navigator services;

b. Ensure that Recovery Support Navigator services are provided in accordance with all EOHHS approved Recovery Support Navigator performance specifications and Recovery Support Navigator Medical Necessity Criteria;

c. Adopt authorization, concurrent review, notification or registration procedures, and documentation parameters for Recovery Support Navigators in accordance with a uniform standard established by EOHHS. The Contractor shall:

1) Assist Providers in learning how to utilize the Contractor's authorization and concurrent review procedures with respect to Recovery Support Navigator services;

2) Ensure that the authorization procedures established for Recovery Support Navigator allow for at least the first 90 days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of Recovery Support Navigator services as further specified by EOHHS;

d. For Recovery Support Navigator services, establish Provider rates and use procedure codes as set forth in **Section 2.8.D.7**.

7. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for managing the Opioid Treatment Program (OTP) Provider Network. The Contractor shall:

a. Cover and pay for the administering and dispensing of methadone, buprenorphine, and naltrexone through its OTP Network Providers. If the

Contractor utilizes a Material Subcontractor for Behavioral Health Services, cover and pay for such services solely through such Material Subcontractor and require such Material Subcontractor to comply with the requirements in this **Section 2.9.C**;

b. Use the codes specified by EOHHS for the coverage of methadone, buprenorphine, and naltrexone and related services when delivered by OTP Network Providers; and

c. Ensure that OTP Network Providers follow the MassHealth Drug List for any drugs related to the provision of OTP.

d. For Opioid Treatment Program Services, establish Provider rates and use procedure codes as set forth in **Section 2.8.D.7**.

8. The Contractor shall require Hospitals with DMH-licensed beds in its Provider Network to comply with the Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards that follow, as they appear in DMH Licensing Division Bulletin #19-01 (or any amended or successor bulletin), when delivering Inpatient Mental Health Services in those DMH-licensed beds:

   a. Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric Units within General Hospitals

   b. Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

   c. Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)

   d. Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

   e. For reference, excerpts of DMH Licensing Division Bulletin #19-01, including the relevant Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards, are reprinted in **Appendix G, Exhibit 5**. In the event that the Department of Mental Health amends or supersedes DMH Licensing Division Bulletin #19-01, the amended or superseding bulletin shall be controlling.

9. The Contractor shall require all hospitals in its Provider Network, including those that do not have DMH-licensed beds, to have the capability to treat, in accordance with professionally recognized standards of medical care, all individuals admitted to any unit or bed within the hospital who present with co-occurring behavioral conditions, including, but not limited to, individuals with co-occurring Substance Use Disorders

(SUD), Autism Spectrum Disorder and Intellectual and Developmental Disabilities (ASD/ID/DD), and/or individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk.

10. The Contractor shall, work collaboratively with EOHHS and EOHHS's BH Vendor to support the CBHC program, as further specified by EOHHS, including but not limited to:

    a. Attending regional and statewide meetings on CBHC implementation, operation, and performance;

    b. Participating in CBHC network management and policy development;

    c. Participating in technical assistance and network management activities; and

    d. Ensuring sufficient and appropriate staffing to support the CBHC program.

11. CSP Benefits

    a. Ensure Enrollees have access to CSP services in accordance **with Section 2.7**.

    b. The Contractor shall provide the enhanced care coordination supports described in **Section 2.6.C**, including but not limited to Comprehensive Assessments and Care Plans, for Enrollees who are enrolled in an enhanced care coordination program and receiving Community Support Program services as set forth in **Appendix C**.

    c. Community Support Program for Homeless Individuals (CSP-HI)

        1) Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, under CSP-HI the Contractor shall provide CSP services as set forth in **Appendix C** to enrollees who meet one of the following criteria:

            a) Homeless Enrollees who meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or

            b) Homeless Enrollees who do not meet the "Chronically Homeless" definition but who are also high utilizers of MassHealth services as defined by MassHealth.

        2) The Contractor shall:

            a) Authorize, arrange, coordinate, and provide CSP-HI services as

set forth in **Appendix C** to Enrollees who meet the criteria under **Section 2.9.C.12.c.i**

b) Actively communicate with CSP-HI Providers regarding the provision of CSP-HI services to Enrollees, including coordinating care to ensure that Enrollees' needs are met;

c) Require that Network Providers of CSP-HI have demonstrated experience and employed staff as further specified by EOHHS including Homelessness experience and expertise;

d) Develop Performance Specifications for the delivery of CSP-HI as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

e) Pay CSP-HI Providers a daily rate. Once the Enrollee has obtained housing, continue to pay CSP-HI Providers the daily rate until such a time as the Contractor determines that CSP-HI is no longer medically necessary;

f) Ensure that rates paid for CSP-HI services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure Providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;

g) Designate a single point of contact for CSP-HI to provide information to CSP-HI Providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contact designated for CSP-TPP as described in **Section 2.9.C.12.d**; and

h) Collect and maintain written documentation that the Enrollees receiving CSP-HI meet the definitions under **Section 2.9.C.12.c.i** and as further specified by EOHHS including:

   (i) Documentation of "chronic homelessness" and "homelessness" shall meet the HUD standards for recordkeeping and be generated from the local Continuum of Care Homeless Management Information System (HMIS). If HMIS records are not available, Plans may collect other documents to prove chronic homeless or homeless status, but these shall meet the HUD standards for determining and documenting homelessness; and

(ii) Documentation of “High Utilizer” shall be generated by the Contractor.

3) The Contractor shall further require that any staff of Network Providers of CSP-HI meet the following minimum qualifications:

a) Specialized training or lived experience in behavioral health, BH treatment for co-occurring disorders, trauma-informed care, and Traumatic Brain Injuries;

b) Specialized training or experience in outreach and engagement strategies such as progressive engagement, motivational interviewing, etc.;

c) Knowledge of housing resources and dynamics of searching for housing

d. Community Support Program (CSP) Tenancy Preservation Program

1) Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, under CSP-TPP the Contractor shall provide CSP-TPP services as set forth in **Appendix C** to enrollees who are unstably housed. For the purposes of this section “unstably housed” is defined as an Enrollee who:

a) Has a lease violation directly related to the Enrollee’s Behavioral Health;

b) Is at risk for eviction, as documented by a Notice to Quit or a Notice of Lease Termination (in public housing); and

c) Has a preservable tenancy.

2) The Contractor shall

a) Authorize, arrange, coordinate, and provide CSP-TPP services as set forth in **Appendix C** to Enrollees who meet the criteria under **Section 2.9.C.12.d.i**;

b) Actively communicate with CSP-TPP Providers regarding the provision of CSP-TPP services to Enrollees, including coordinating care to ensure that Enrollees’ needs are met;

c) Require that Network Providers of CSP-TPP have demonstrated experience and employed staff as further specified by EOHHS;

d) Develop Performance Specifications for the delivery of CSP-TPP

as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

e) Pay CSP-TPP Providers a daily rate and continue to pay CSP-TPP Providers the daily rate until such a time as the Contractor determines that CSP-TPP is no longer medically necessary;

f) Ensure that rates paid for CSP-TPP services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure Providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;

g) Designate a single point of contact for CSP-HI to provide information to CSP-HI Providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contact designated for CSP-HI as described in **Section 2.9.C.12.c.2.g**; and

h) Collect and maintain written documentation that the Enrollees receiving CSP-TPP meet the definitions under **Section 2.9.C.12.d.1** as further specified by EOHHS.

e. Community Support Program (CSP) Services for Individuals with Justice Involvement (CSP-JI)

1) 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-JI services as set forth in **Appendix C** to individuals with Justice Involvement as described in this section.

2) The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in **Appendix C** 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:

a) Assisting in enhancing daily living skills;

b) Providing service coordination and linkages;

c) Assisting with obtaining benefits, housing, and healthcare;

d) Developing a safety plan;

e) Providing prevention and intervention; and

f) Fostering empowerment and recovery, including linkages to peer support and self-help groups.

f. For the purpose of this Section, 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.

g. 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 A**; 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.

12. When directed by EOHHS, the Contractor shall maintain agreements with Behavioral Health Supports for Individuals with Justice Involvement Providers, as further specified by EOHHS.

13. The Contractor shall incorporate DMH's Infection Control Competencies/Standards, as set forth in Attachments A and B to DMH Licensing Bulletin 20-05R, or successor guidance, in its contracts with DMH-licensed providers of Inpatient Mental Health Services. The Contractor shall review such facility's compliance with the applicable DMH requirements as part of the Contractor's program integrity efforts pursuant to **Section 2.3.D**. The Contractor shall promptly report any noncompliance with the applicable DMH standards to EOHHS and shall treat such noncompliance in accordance with the Contractor's program integrity activities pursuant to **Section 2.3.D**.

D. Behavioral Health Clinical Assessment and Treatment Planning

The Contractor shall:

1. Ensure that all Behavioral Health Providers prepare an individualized written Behavioral Health Clinical Assessment and treatment plan for all Enrollees starting behavioral health treatment and for Behavioral Health Services to be provided upon discharge from any level of behavioral health care;

2. Ensure that the Behavioral Health Clinical Assessments are conducted by behavioral health Providers who have training and experience that match the Enrollee's clinical needs based on their presenting behavioral health problem(s) and diagnosis;

3. Require and monitor that Behavioral Health Clinical Assessments and treatment plans are completed within the time frames set forth below:

    a. Acute inpatient treatment: within 24 hours of admission;

    b. 24-Hour Diversionary Services: within 24 hours of admission;

    c. Non-24-Hour Diversionary Services: by the end of the second visit; and

    d. Behavioral Health Outpatient Services: in accordance with DPH regulation 105 CMR 140.540;

4. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers are in writing, dated and signed, and include, at a minimum, the following:

    a. History of presenting problem;

    b. Chief complaints and symptoms;

    c. Strengths of the Enrollees and caregivers that will be used in treatment planning;

    d. Past mental health and/or substance use disorder history;

    e. Past medical history;

    f. Family, social history and linguistic and cultural background;

    g. Current substance use disorders;

    h. Mental status exam;

    i. Present medications and any allergies;

    j. Diagnosis;

    k. Level of functioning;

    l. Treatment plan;

    m. Crisis assessment planning;

    n. Name of and contact information for the PCP;

o. Clinical formulation, rationale for treatment, recommendations and strengths; and

p. Use of the CANS Tool for Enrollees under age 21 and for Enrollees aged 21 and over, other behavioral health screening tools identified and approved by EOHHS;

5. Ensure that Behavioral Health Clinical Assessments conducted by Behavioral Health Providers for individuals under age 21, where the CANS Tool is required, are provided by Behavioral Health Providers who are certified CANS Providers;

6. Ensure the ability to access and use the CANS IT System and data contained therein, and shall, as further directed by EOHHS, participate in any testing or development processes as necessary for EOHHS to build the CANS IT System;

7. In collaboration with and as further directed by EOHHS, develop and implement network quality improvement activities directed at ensuring that Network Providers are using the CANS Tool in their Behavioral Health Clinical Assessments for Enrollees under the age of 21; and can access and utilize the CANS IT System to input CANS assessments;

8. Require and monitor compliance with the following:

a. That a Behavioral Health multidisciplinary team is assigned to each Enrollee within 24 hours of an acute Behavioral Health Inpatient or 24-Hour Diversionary Services admission;

b. That the Behavioral Health multidisciplinary team meets and reviews the Enrollee's treatment plan within 24 hours of an acute Behavioral Health Inpatient Services admission or 24-Hour Diversionary Services admission, modifies the treatment plans as needed and, during the Enrollee's Behavioral Health Inpatient Services stay, periodically meets to review and modify the treatment plan; and

c. That the Behavioral Health multidisciplinary team reviews facility-based, outpatient care in accordance with 105 CMR 140.540;

9. Ensure that for all state agency clients a release of information is requested to be used to inform the identified agency of the Enrollee's current status;

10. Ensure that for all state agency clients, the treatment plan specifies all Behavioral Health Services required during the acute Behavioral Health Inpatient Services stay, identifies discharge plans and, when appropriate, indicates the need for DMH Community-Based Services;

11. When it is anticipated that the Enrollee's discharge plan shall include DMH Community-Based Services, ensure that the DMH Community-Based Services case managers participate in each treatment team meeting; and

12. Ensure that Enrollees, their guardians, and family members, as appropriate, are included in the development and modification of the Enrollee's treatment plan, in the treatment itself, and that they attend all treatment plan meetings, provided that for adult Enrollees, the Enrollee has rendered their consent for these individuals to participate in the treatment and treatment plan-related activities described herein.

E. Treatment and Discharge Planning at Behavioral Health Inpatient and 24-Hour Diversionary Settings

The Contractor shall, as further directed by EOHHS, including but not limited to in Managed Care Entity Bulletins, implement policies and procedures that (1) ensure timely and effective treatment and Discharge Planning; (2) establish the associated documentation standards; (3) involve the Enrollee and the Contractor; and (4) begin on the day of admission. Treatment and Discharge Planning shall include at least:

1. Identification and assignment of a facility-based case manager for the Enrollee. This staff member shall be involved in the establishment and implementation of treatment and Discharge Planning;

2. Identification of the new acute clinical services, as well as supports, covered services and the continuing care with any established Providers, and the identification of any new Providers and the covered services that will be added;

3. Identification of the Enrollee's state agency affiliation, release of information, and coordination with any state agency case worker assigned to the Enrollee;

4. Identification of non-clinical supports and the role they serve in the Enrollee's treatment and after care plans;

5. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards set forth in **Section 2.9.B.2.;**

6. Recommendation for the initial frequency of aftercare services and supports;

7. Identification of barriers to aftercare and timely discharge of Enrollees, including but not limited to Enrollees on AND, and the strategies developed to address such barriers;

8. Procedures to monitor for the earliest identification of the next available after care resource required for the Enrollee who has remained in the Behavioral Health Inpatient and 24-Hour Diversionary setting for non-medical reasons (e.g., the recommended aftercare resources were not yet available);

9. Assurance that Inpatient and 24-Hour Diversionary Providers provide a discharge plan following any Behavioral Health admission to other providers working with the Enrollee and PCP;

10. Ensure that Providers invite Enrollees' family members, their guardians, outpatient individual practitioners, CP, ACO Care Management, Care Team, state agency staff, as appropriate and if applicable, and other identified supports to participate in Discharge

Planning to the maximum extent practicable, including behavioral health treatment team meetings, developing the discharge plan, when appropriate, and for adult Enrollees, only when the Enrollee has consented to their involvement;

11. Ensure that services contained in the Enrollee's discharge plan are offered and available to Enrollees within seven business days of discharge from an inpatient setting;

12. Ensure that Enrollees who require medication monitoring will have access to such services within 14 business days of discharge from a Behavioral Health Inpatient setting;

13. Require that Behavioral Health Network Providers, upon admission of an Enrollee:

    a. Assign a case manager or other appropriate staff;

    b. Develop, in collaboration with the Enrollee including Enrollees on AND, a plan for the Enrollee's discharge to a more appropriate level of care, service or program;

    c. Ensure that the treatment and discharge plan for Enrollees who are state agency clients is coordinated with appropriate state agency staff;

    d. Make best efforts to ensure a smooth transition to the next service or to the community; and

    e. Document all efforts related to these activities, including the Enrollee's active participation in Discharge Planning; and

14. Ensure that a process is in place for identifying Enrollees who remain in an acute inpatient hospital or community based acute treatment and authorized as an Administratively Necessary Day and report to EOHHS as required in **Appendix A**. The Contractor shall produce upon EOHHS request discharge plans for all such Enrollees.

F. Network Management of the Behavioral Health Provider Network

1. The Contractor shall report to EOHHS on its Behavioral Health Provider Network Management strategy activities and progress in accordance with **Appendix A**.

2. The Contractor shall develop and implement a Behavioral Health Provider Network Management strategy that shall include the following:

    a. A system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

    b. A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals;

    c. A system for identifying challenges and gaps in timely access to care, stratified

by populations and geographies, and a strategy for addressing and managing such challenges. Such strategy shall consider contracting with additional Network Providers, payment strategies, and additional supports for members;

d. On-site visits to Network Providers for quality improvement purposes; and

e. In collaboration with and as further directed by EOHHS, the development and implementation of network quality improvement activities directed at ensuring that Network Providers are using the CANS Tool in their Behavioral Health Clinical Assessments and as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services for Enrollees under the age of 21; and, access and utilize the CANS IT System to input information gathered using the CANS Tool and the determination of whether or not the assessed Enrollee is suffering from an SED.

G. Cultural and Linguistic Competence

The Contractor shall ensure that:

1. Multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area(s), 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(s);

3. Its Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, members experiencing homelessness, members with disabilities, and other special populations served under the Contract;

4. It identifies opportunities to improve the availability of readily available fluent staff or skilled translation services in Enrollees preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care as further specified in **Section 2.21.E.**

H. Provider Screening, Credentialing, Recredentialing, and Board Certification

1. Provider Screening

The Contractor shall:

a. Develop and maintain policies and procedures to implement the Provider screening requirements set forth in this **Section 2.9.H**. Such policies and procedures shall include that the Contractor shall search for Providers and prospective Providers in the databases set forth in **Appendix I**, along with other

exclusion databases specified by EOHHS, in accordance with this section.

b. Search for individual Providers, Provider entities, and owners, agents, and managing employees of Providers.

1) To determine these searches, the Contractor shall identify the appropriate individuals to search and evaluate by using, at a minimum, the federally required disclosures the Contractor obtained from the Provider or prospective Provider pursuant to this section;

2) The Contractor shall obtain federally required disclosures, using the MassHealth Federally Required Disclosures Form, from all Providers and prospective Providers 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 and credentialing and recredentialing packages. The Contractor shall maintain such information in a manner which can be periodically used by the Contractor for Provider screening activities described in this section and, if needed, provided to EOHHS in accordance with this Contract or relevant state and federal laws and regulations.

c. Search at the time of enrollment and re-enrollment, credentialing and recredentialing, and revalidation, and at any other times specified in **Appendix I** in order to identify newly excluded and sanctioned individuals and entities;

d. As of the date indicated in any exclusion database, not contract with a provider and shall terminate a contract with any Provider found in any exclusion database at **Appendix I** and any other databases specified by EOHHS;

e. Submit an Excluded Provider Monitoring Report to EOHHS, as described in **Appendix A,** to demonstrate compliance with this **section**. At the request of EOHHS, the Contractor shall provide additional information which may include, but shall not be limited to computer screen shots from exclusion databases**;**

f. Screen Providers and prospective Providers in accordance with this **Section 2.9.H**;

2. Provider Credentialing and Recredentialing

The Contractor shall:

a. 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:

1) Submit such policies and procedures annually to EOHHS, if amended;

2) Demonstrate to EOHHS, by reporting in accordance with **Appendix A** that all Providers within the Contractor's Provider Network are credentialed according to such policies and procedures;

3) Designate and describe the departments(s) and person(s) at the Contractor's organization who will be responsible for Provider credentialing and re-credentialing;

b. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Providers and all other licensed or certified Providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with:

1) 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; and

2) 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;

d. Conduct a site visit is conducted in accordance with recognized managed care industry standards and relevant federal regulations;

3. Recredentialing

The Contractor shall maintain documented re-credentialing processes that shall:

a. Occur at least every three years (thirty-six months);

b. Take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews conducted pursuant to **Section 2.14.C.2**, utilization management information collected pursuant to **Section 2.14.C.3**, and Enrollee satisfaction surveys collected pursuant to **Section 3.1.B.4**;

c. Require 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; and

d. 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;

4. The Contractor shall notify EOHHS when a Provider fails credentialing or re-credentialing because of a program integrity reason, including those reasons described in this **Section 2.9.H**, and shall provide related and relevant information to EOHHS as required by EOHHS or state or federal laws, rules, or regulations;

5. As further directed by EOHHS, the Contractor shall share information collected pursuant to the credentialing activities described in this section with EOHHS, including facilitating EOHHS efforts to standardize Provider enrollment or credentialing processes between EOHHS and the Contractor.

6. Program Integrity Related Actions and Management of Provider Network

   a. 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:

      1) Terminate, suspend, or decline a provider from its Network as appropriate;

      2) Upon notice from EOHHS, not authorize such providers to treat Enrollees and shall deny payment to such providers for services provided

   b. The Contractor shall, as of the date indicated in any exclusion database, not contract with a provider and shall terminate a contract with any Provider found in any exclusion database at **Appendix I** and any other databases specified by EOHHS;

   c. The Contractor shall 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.

   d. Pursuant to sections 1903(i), including 1903(i)(2)(B), of the Social Security Act, the Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, title VXIII, or XX or under title XIX pursuant to sections 1128,

1128A, 1156 or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after reasonable time period after reasonable notice has been furnished to the person);

e. Payment Suspensions for Providers

In the event EOHHS suspends payment to a provider, including but not limited to when there is an investigation of a credible allegation of fraud, the Contractor shall also suspend such payment, if directed to do so by EOHHS and in accordance with **Section 2.3**; provided, however, that the Contractor may propose to EOHHS that there is good cause for the Contractor not to suspend, or to suspend in part, such payments for the reasons set forth below. EOHHS shall approve or deny the Contractor's proposal.

1) The Contractor may propose that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to a provider against which there is an investigation of a credible allegation of fraud, for any of the following reasons:

a) Other available remedies implemented by the Contractor more effectively or quickly protect Medicaid funds.

b) The Contractor determines, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed.

c) Enrollee access to items or services would be jeopardized by a payment suspension because either:

(i) The provider is the sole community physician or the sole source of essential specialized services in a community, or

(ii) The provider serves a large number of beneficiaries within a HRSA-designated medically underserved area.

d) Law enforcement declines to certify that a matter continues to be under investigation.

e) The Contractor determines that payment suspension is not in the best interests of the Medicaid program.

2) The Contractor may propose that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider against which there is an investigation of a credible allegation of fraud if any of the following

reasons:

a) Enrollee access to items or services would be jeopardized by a payment suspension because either:

(i) The provider is the sole community physician or the sole source of essential specialized services in a community, or

(ii) The provider serves a large number of beneficiaries within a HRSA-designated medically underserved area.

b) The Contractor determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

c) The Contractor can demonstrate both of the following:

(i) The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and

(ii) The Contractor determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

d) Law enforcement declines to certify that a matter continues to be under investigation.

e) The State determines that payment suspension only in part is in the best interests of the Medicaid program.

f. The Contractor shall develop and maintain policies and procedures that support a process for the recoupment of payments from Providers identified as excluded by appearing on any exclusion or debarment database, including those at **Appendix N**, in accordance with the requirements **Section 2.3.D.4** for overpayments. The Contractor shall maintain documentation to support the date and activities by which recoupment efforts are established for claims paid after the date indicated in the exclusion database. At a minimum, the Contractor shall document recoupment efforts including outreach to the Provider, voiding claims, and establishing a recoupment account; and

g. Provider For Cause Termination

The Contractor shall terminate a Network Provider for cause as further described in this section.

1) For the purposes of this section:

   a) "for cause" shall be defined as reasons related to fraud, integrity, or quality issues that run counter to the overall success of MassHealth as further described in **Sections 2.9.H.9.g.2-3** below, and

   b) "termination" shall be defined as termination of a Network Provider's privilege to bill the Contractor, of which appeal rights have been exhausted or the time for appeal has expired.

2) Mandatory Termination of Network Provider

   The Contractor shall terminate a Network Provider, and such termination shall be considered for cause, in the following cases:

   a) Medicare terminates a Network Provider for one of the reasons under 42 CFR 424.535, and such termination which would require EOHHS to terminate such provider from MassHealth;

   b) All circumstances set forth in 42 CFR 455.416 where EOHHS would be required to terminate a provider from MassHealth; and

   c) All circumstances set forth in 130 CMR 450.212(A)(1)-(5) where EOHHS would be required to terminate a provider from MassHealth.

3) Discretionary Termination of Network Provider

   The Contractor may terminate a Network Provider, and the Contractor may consider such terminations to be for cause terminations, in the following cases:

   a) As described in 42 CFR 455.416(g), the Network Provider provided false or misleading information or the Contractor is unable to verify the identity of the provider.

   b) Other reasons related to fraud, integrity or quality, including when the Network Provider:

      (i) Or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel of the Network Provider is:

(a) Excluded from Medicare, Medicaid, or any other health care program as defined in 42 CFR 1001.2;

(b) Debarred, suspended, or otherwise excluded from participating in any other federal program or activity in accordance with Federal Acquisition Streamlining Act and 45 CFR part 76; or

(c) Subject to any other state or federal exclusion.

(ii) Loses its license as a result of an adverse licensure action

(iii) Abuses billing privileges, such as selling to another its billing number or submitting a claim for services that could not have been furnished (e.g., the physician or Enrollee were not present when the services were supposedly furnished or the equipment necessary to perform a service was not present).

(iv) Has its ability to prescribe drugs suspended or revoked by an applicable federal or state licensing or administrative body or has a pattern of improperly prescribing drugs in a manner that does not meet Medicaid requirements.

(v) Bills for services furnished while its license is suspended.

(vi) Is not in compliance with provider enrollment requirements, including but not limited to those set forth for MassHealth providers at 130 CMR 450.212(A), or fails any applicable onsite review.

(vii) Otherwise poses a threat of fraud, waste, or abuse.

4) Reporting

The Contractor shall notify EOHHS when it terminates a Provider for cause, as defined above, within three (3) business days of such termination.

7. This **Section 2.9.H** does not preclude the Contractor from suspending or terminating Providers for reasons unrelated to the possible suspension or termination from

participation in MassHealth, Medicare or another state's Medicaid program;

8. The Contractor shall report to EOHHS in accordance with **Appendix A** to demonstrate that it has implemented the actions necessary to comply with this **section**; and

9. The Contractor shall notify EOHHS when it terminates, suspends, or declines a Provider from its Network for any reason, including a program integrity reason, and shall provide related and relevant information to EOHHS as required by EOHHS or state or federal laws, rules, or regulations;

I. Provider Profiling

1. The Contractor shall conduct profiling activities for PCPs, Behavioral Health Providers and, as directed by EOHHS, other Provider types, at least annually. As part of its quality activities, the Contractor shall document the methodology it uses to identify which and how many Providers to profile, and to identify measures to use for profiling such Providers.

2. Provider profiling activities shall include, but are not limited to:

   a. Developing Provider-specific reports that include a multi-dimensional assessment of a Provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

   b. Establishing Provider, group, or regional benchmarks for areas profiled, where applicable, including MassHealth-specific benchmarks, if any;

   c. Providing feedback to Providers regarding the results of their performance and the overall performance of the Provider Network; and

   d. Designing and implementing quality improvement plans for Providers who receive a relatively high denial rate for prospective, concurrent, or retrospective service authorization requests, including referral of these Providers to the Network Management staff for education and technical assistance and reporting results annually to EOHHS.

3. The Contractor shall use the results of its Provider profiling activities to identify areas of improvement for Providers, and/or groups of Providers. The Contractor shall:

   a. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor standards or improvement goals;

   b. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures;

c. Conduct on-site visits to Network Providers for quality improvement purposes; and

d. At least annually, measure progress on the Provider Network and individual Providers' progress, or lack of progress, towards meeting such improvement goals.

4. The Contractor shall maintain regular, systematic reports, in a form and format approved by EOHHS, of the above-mentioned Provider profiling activities and related Quality Improvement activities pursuant to **Section 2.14 and Appendix B**. Moreover, the Contractor shall submit to EOHHS, upon request, such reports or information that would be contained therein. The Contractor shall also submit summary results of such Provider profiling and related Quality Improvement activities as a component of its annual evaluation of the QM/QI program.

J. Provider Education

The Contractor shall establish ongoing Provider education, including but not limited to, the following issues:

1. ACO Covered and Non-ACO Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis shall be placed on areas that vary from many commercial coverage rules (e.g., EPSDT Services, Early Intervention Services, therapies and DME/Medical Supplies);

2. The relevant requirements of this Contract;

3. The Contractor's quality improvement efforts and the Provider's role in such a program;

4. The Contractor's continuity of care policies and procedures, as described in **Section 2.4.F**;

5. The Contractor's policies and procedures, especially regarding in and out-of-network referrals;

6. Flexible Services

7. The Community Partners program; and

8. The importance of documenting Enrollee's health-related social needs (HRSN) using applicable ICD-10 z-codes on any claims submitted for services where an Enrollee's HRSN have been identified.

9. For PCPs, education and information on:

a. All EPSDT and PPHSD mandated screenings for children and adolescents up to age 21;

b. Issues of adolescence, including but not limited to, sexual activity, drug and alcohol use, and school and family concerns;

c. Issues, including but not limited to, the following:

1) Pre-conception health concerns, including folic acid administration; family planning guidance; nutrition; osteoporosis prevention; HIV and STI prevention; and HIV testing prior to becoming pregnant; and

2) Pre- and post-menopause concerns, including hormone treatment, osteoporosis, nutrition and cardiac concerns;

d. Issues concerning persons with disabilities, including but not limited to:

1) The needs of persons with disabilities;

2) Assisting Enrollees with disabilities in maximizing Enrollees' involvement in the care they receive, and in making decisions about such care;

3) Providing information on accessing day, therapeutic and supportive services, if applicable (i.e., day habilitation, adult day health, adult foster care, etc.) or other community-based services; and

4) Maximizing for Enrollees with disabilities, independence and functioning through health promotion and preventive care, decreased hospitalization and emergency room use, and the Enrollee's ability to be cared for at home, and providing resources and referrals to agencies that specialize in community services for persons with disabilities;

e. Issues concerning adults and regular care that they should be receiving according to the Massachusetts Health Quality Partners (MHQP) Adult Preventive Care Guidelines; and

f. Issues concerning other special populations including the individuals experiencing homelessness, high-risk pregnant individuals, and children in the care or custody of DCF and youth affiliated with DYS (either detained or committed).

10. As directed by EOHHS, the Contractor shall develop and distribute provider bulletins or comparable communications concerning the CBHI or shall coordinate the development and distribution with all other Accountable Care Partnership Plans, MassHealth-contracted MCOs and prepaid inpatient health plans. The content of these communications is subject to prior approval by EOHHS and may be modified in whole or in part at the discretion of EOHHS.

a. With respect to behavioral health screening, the Contractor shall develop and distribute Provider communications that shall give Providers information that describes:

1) The standardized behavioral health screening tools approved by EOHHS;

2) How to provide Medically Necessary treatment services or refer MassHealth Standard and CommonHealth Enrollees under age 21 for Medically Necessary treatment services in accordance with EPSDT requirements;

3) How to provide Medically Necessary treatment services or refer MassHealth Family Assistance Enrollees under age 21 for Medically Necessary treatment services included in their benefit package;

4) The Behavioral Health Services which are available when Medically Necessary including, but not limited to, Diversionary Services currently available and how Enrollees can access those services; and

5) The CBHI Services that will be required including anticipated timelines for implementation.

b. The Contractor shall prepare and disseminate, as directed by EOHHS and subject to EOHHS review and approval, Provider Alerts or similar communications and education materials that explain to Providers:

1) The CANS Tool;

2) The process and procedures for obtaining required CANS training and certification;

3) The process and procedures for accessing and utilizing the CANS IT System;

4) Any processes for billing for Behavioral Health Clinical Assessments using the CANS; and

5) Any other information about Behavioral Health Clinical Assessments using the CANS or the CANS IT System. These communications shall be disseminated to Network Providers who provide the services described in **Section 2.23.A.1.a**, in a timeframe established by EOHHS.

11. As directed by EOHHS, the Contractor shall conduct at least one forum per year to educate PCPs and Behavioral Health Providers about the value of integrated and coordinated service delivery and the importance of primary care and of behavioral health screenings and appropriate referrals to Behavioral Health Providers. If requested or approved by EOHHS, the Contractor shall coordinate these forums with EOHHS or other MassHealth–contracted Accountable Care Partnership Plans, MCOs, and prepaid inpatient health plans. These forums shall:

a. Include a written curriculum, which shall be prior approved by EOHHS, and may be modified by EOHHS in whole or in part at the discretion of EOHHS;

b. Include at least one forum per year for Behavioral Health Providers on behavioral health topics to be prior approved by EOHHS; and

c. Meet any further requirements, as directed by EOHHS, or that the Contractor determines necessary, to assure that Providers receive accurate information about EPSDT and the CBHI that is prior approved by EOHHS.

12. As directed by EOHHS, the Contractor shall conduct at least one forum per year to encourage clinical performance activities by Behavioral Health Providers consistent with the principles and goals of the CBHI. If requested or approved by EOHHS, the Contractor shall coordinate these forums with EOHHS or other MassHealth-contracted Accountable Care Partnership Plans, MCOs, and prepaid inpatient health plans. These forums shall:

    a. Include a written curriculum, which shall be prior approved by EOHHS, and which may be modified by EOHHS, in whole or in part at the discretion of EOHHS; and

    b. Meet any further requirements that are directed by EOHHS, or that the Contractor determines necessary, to assure that Providers receive accurate information about EPSDT and the CBHI that have been approved by EOHHS.

13. For all Providers, issues concerning individuals with disabilities, such as cognitive, intellectual, mobility, psychiatric, and sensory disabilities as defined in **Section 1**, including but not limited to:

    a. Various types of chronic conditions and disabilities prevalent in Massachusetts;

    b. Compliance with the American with Disabilities Act and other federal and state laws related to serving individuals with disabilities;

    c. Information related to communication access, medical equipment access, physical access, and access to programs;

    d. Types of barriers individuals with disabilities face in the health arena and accommodation and access needs to face such barriers;

    e. Person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model;

    f. Working with enrollees with mental health diagnoses, including crisis prevention and treatment; and

    g. Peer-run, community-based rehabilitation and long-term support services.

14. The Contractor or its designee shall ensure that meaningful and appropriate trainings to advance Health Equity are periodically received by all staff and Network Providers (contracted or directly employed) that interact with Medicaid Enrollees (through operations, delivery of services, or other member-facing roles (e.g., security officer or receptionist)). The Contractor shall document staff participation in required training and address staff non-compliance with training policies.

    The training content shall include, at a minimum, the following:

    a. An overview of the organization's Health Equity strategy, including populations prioritized for intervention;

    b. The role(s) trainees can play to promote and achieve Health Equity;

    c. The importance of and best practices related to:

        1) Collecting self-reported social risk factor data such as race, ethnicity, language, disability (RELD), sexual orientation and gender identity (SOGI);

        2) Addressing inequities experienced by enrollees with social risk factors, including but not limited to race, ethnicity, language, disability, sexual orientation, and gender identity

        3) Adherence to CLAS standards as described in **Section 2.21.E**

        4) The role of trauma-informed practices for marginalized individuals

        5) Identifying and mitigating the impact of implicit biases on delivery of high quality, equitable health care

        6) Anti-racism, as further specified by EOHHS, including topics such as but not limited to the role of structural and institutional racism in health care

    a. A description of how the content reinforces the Contractor's mission, values, and priorities and how trainees have applied or are expected to apply the training to their work.

    b. The Contractor shall make its Health Equity, Anti-Racism, Implicit Bias and related trainings available to all its sub-contracted Community Partners.

    c. As part of the Health Equity Strategic Plan and Report, the Contractor provide an overview of its Health Equity trainings

    d. EOHHS may require the Contractor to implement additional training programs related to Health Equity.

e. As directed by EOHHS, The Contractor shall evaluate the effectiveness of its training programs on an annual basis.

K. Marketing Activity Requirements

The Contractor shall require that its Providers comply with the Marketing activity requirements found in **Section 2.12.**

L. Integrated Care Incentive Payment

For any Contractor whose ACO Partner is a non-federal, non-state-owned public hospital, the Contractor shall:

1. For each Contract Year, collect the following information, in a form and format and at times specified by EOHHS, from such hospital:

   a. At the time of the midpoint evaluation specified by EOHHS:

      1) Progress on certain quality measures and related performance goals specified by EOHHS; and

      2) Additional information as specified by EOHHS.

   b. At the time of the year end evaluation specified by EOHHS:

      1) Performance information on certain quality measures specified by EOHHS; and

      2) Additional information as specified by EOHHS.

2. Submit to EOHHS, at a time and in a manner specified by EOHHS:

   a. The information the Contractor collected in accordance with **Section 2.9.L.1** above; and

   b. A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

3. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments within 3 days of receiving payment from EOHHS, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to such non-federal, non-state-owned public hospitals.

M. Clinical Quality Incentive for Acute Hospitals

The Contractor shall:

1. For each Contract Year, collect the following information, in a form and format and at

times specified by EOHHS, from acute care hospitals that have executed the MassHealth Acute Care Hospital RFA (RFA):

a. At the time of the midpoint evaluation specified by EOHHS:

1) Progress on certain measures targeting clinical quality and related performance goals specified by EOHHS; and

2) Additional information as specified by EOHHS.

b. At the time of the year end evaluation specified by EOHHS:

1) Performance information on measures targeting clinical quality specified by EOHHS; and

2) Additional information as specified by EOHHS.

2. Submit to EOHHS, at a time and in a manner specified by EOHHS:

a. The information the Contractor collected in accordance with **Section 2.9.M.1** above; and

b. A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

3. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments, pursuant to 42 CFR 438.6c and as specified by EOHHS, to acute care hospitals that have executed the RFA. The Contractor shall make such payments to such Providers within 14 calendar days of receiving payment from EOHHS.

N. Performance Improvement Initiative for Professional Services

The Contractor shall:

1. For each Contract Year, collect the following information, in a form and format and at times specified by EOHHS, from hospitals affiliated with the state-owned medical school:

a. At the time of the midpoint evaluation specified by EOHHS:

1) Progress on certain measures targeting professional services and related performance goals specified by EOHHS; and

2) Additional information as specified by EOHHS.

b. At the time of the year end evaluation specified by EOHHS:

1) Performance information on measures targeting professional services specified by EOHHS; and

2) Additional information as specified by EOHHS.

2. Submit to EOHHS, at a time and in a manner specified by EOHHS:

a. The information the Contractor collected in accordance with **Section 2.9.N.1** above; and

b. A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

3. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to the hospitals affiliated with the state-owned medical school.

O. Other Provider Requirements

As directed by EOHHS, the Contractor shall develop and implement a network of Providers to provide a Targeted Case Management benefit for high risk children with medical complexity who meet the medical necessity criteria for the service, as further specified by EOHHS.

P. Other ACO-Directed Payments

EOHHS may amend the contract to require the Contractor to administer other value-based incentive payments consistent with 42 CFR 438.6(c).

Q. Hospital ED-based Crisis Evaluation

1. The Contractor shall pay hospitals for Emergency Department-based behavioral health crisis evaluations as set forth in **Appendix C** at or above 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 unless otherwise directed by EOHHS. 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 Mobile Crisis Intervention teams for ED-based behavioral health crisis evaluations provided in the Emergency Department.

Section 2.10 Accessibility and Availability

The Contractor shall ensure adequate access to ACO Covered Services for all Enrollees and shall further facilitate access to Non-ACO Covered Services. All such services shall be accessible and available to Enrollees in a timely manner. Accessibility shall be defined as the extent to which the Enrollee can obtain services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. Availability shall be defined as the extent to which the Contractor geographically distributes practitioners of the appropriate type and number to meet the needs of its Enrollees.

A. General

The Contractor shall:

1. Assure EOHHS that it has the capacity to serve Enrollees in accordance with the access and availability standards specified in this section by submitting reports in a form and format specified by EOHHS as set forth in **Appendix A**;

2. Whenever there is a significant change in operations of the Provider Network or significant changes to the Provider Network itself that would affect the adequacy and capacity of services, assure EOHHS that it continues to have the capacity to serve Enrollees in accordance with the access and availability standards specified in this section by submitting reports in a form and format specified by EOHHS, including those set forth in **Appendix A**. Significant changes shall include, but are not limited to:

    a. Changes in ACO Covered Services;

    b. Enrollment of a new population in the Contractor's Plan;

    c. Changes in the Contractor's Service Area(s);

    d. Changes in Provider payment methodology; and

    e. Challenges that the Contractor forecasts in its Providers having capacity to serve Enrollees in accordance with the standards set forth in this section.

3. If not in compliance with the access and availability standards specified in this section, take corrective action necessary to come into compliance with such standards;

4. Ensure access to ACO Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that Network Providers are aware of and comply with such laws so that physical and communication barriers do not inhibit Enrollees from obtaining services under the Contract;

5. Have a system in place to monitor, verify, and document meeting access and availability standards, including appointment wait times. Such system shall include "secret shopper" activities as further specified by EOHHS.

    a. The Contractor shall use statistically valid sampling methods to monitor

compliance with the accessibility standards set forth in this section and shall promptly address any deficiencies, including but not limited to taking corrective action if there is failure to comply by a Provider.

6. The Contractor shall evaluate and report on its compliance with the access and availability standards and on its "secret shopper" and other verification activities in accordance with **Appendix A**. The Contractor shall ensure all information submitted in such reports are up-to-date, accurate, and complete, including but not limited to information contained in any Provider directories and Provider lists.

B. Accessibility

The Contractor shall ensure that Enrollees have access to ACO Covered Services as provided below.

1. Physical Health Services

a. Emergency Services

1) Immediately upon Enrollee presentation at the service delivery site, including non-network and out-of-area facilities; and

2) In accordance with 42 U.S.C. §1396u-2(b)(2) and 42 CFR 434.30, provide coverage for Emergency Services to Enrollees 24-hours a day and seven days a week without regard to prior authorization or the Emergency Service Provider's contractual relationship with the Contractor.

b. Primary Care

1) Within 48 hours of the Enrollee's request for Urgent Care;

2) Within 10 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

3) Within 45 calendar days of the Enrollee's request for Non-Symptomatic Care, unless an appointment is required more quickly to assure the provision of screenings in accordance with the schedule established by the EPSDT Periodicity Schedule in Appendix W of all MassHealth provider manuals, per 130 CMR 450.141.

c. Primary Care or Urgent Care – during extended hours to reduce avoidable inpatient admissions and emergency department visits, as further specified by EOHHS;

d. Specialty Care

1) Within 48 hours of the Enrollee's request for Urgent Care;

2) Within 30 calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

3) Within 60 calendar days for Non-Symptomatic Care.

e. For Enrollees newly placed in the care or custody of DCF

1) Within 7 calendar days of receiving a request from a DCF caseworker, a DCF Health Care Screening shall be offered at a reasonable time and place. Such DCF Health Care Screening shall attempt to detect life threatening conditions, communicable diseases, and/or serious injuries, or indication of physical or sexual abuse; and

2) Within 30 calendar days of receiving a request from a DCF caseworker, a comprehensive medical examination, including all age appropriate screenings according to the EPSDT Periodicity Schedule shall be offered at a reasonable time and place.

f. All Other Services - in accordance with usual and customary community standards.

g. In accordance with 42 CFR 438.206(c)(1)(iii), the Contractor shall make ACO Covered Services available 24 hours a day, seven days a week when medically necessary.

2. Behavioral Health Services (as set forth in **Appendix C**)

a. Emergency Services - Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present at any qualified Provider, whether a Network Provider or a non-Network provider.

b. AMCI/YMCI Services - Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present for such services.

c. Urgent Care - Within 48 hours for services that are not Emergency Services or routine services.

d. All Other Behavioral Health Services - Within 14 calendar days.

e. For services described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

1) Non-24-Hour Diversionary Services – within two calendar days of discharge;

2) Medication Management – within 14 calendar days of discharge;

3) Other Outpatient Services – within seven calendar days of discharge; and

4) Intensive Care Coordination Services – within the time frame directed by EOHHS.

3. The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or MassHealth Fee-For-Service if the Provider serves only Enrollees or other Members.

4. The Contractor may request an exception to the access standards set forth in this section by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to, or better than, the usual and customary community standards for accessing care. Upon approval by EOHHS, the Contractor shall notify Enrollees in writing of such alternative access standards.

C. Availability

The Contractor shall execute and maintain written contracts with Providers to ensure that Enrollees have access to ACO Covered Services within a reasonable distance and travel time from the Enrollee's residence, as provided below and in **Appendix N**. In determining compliance with this section and **Appendix N**, the Contractor shall take into account only Providers with open panels and both walking and public transportation.

1. Primary Care Providers

a. The Contractor shall develop and maintain a network of Primary Care Providers that ensures PCP coverage and availability throughout the Service Area 24 hours a day, seven days a week.

b. The Contractor shall maintain a sufficient number of PCPs, defined as one adult PCP for every 750 adult Enrollees and one pediatric PCP for every 750 pediatric Enrollees throughout all of the Contractor's Service Areas set forth in **Appendix F**. EOHHS may approve a waiver of the above ratios in accordance with federal law.

c. The Contractor shall include in its Network a sufficient number of appropriate PCPs to meet the time and distance requirements set forth in **Appendix N**. An appropriate PCP is defined as a PCP who:

1) Is open at least 20 hours per week;

2) Has qualifications and expertise commensurate with the health care needs of the Enrollee; and

3) Has the ability to communicate with the Enrollee in a linguistically appropriate and culturally sensitive manner.

d. Problems Covering a Service Area

1) The Contractor shall promptly identify to EOHHS Service Areas about which it has near-future concerns, or in which it sees upcoming obstacles in meeting the time and distance requirements with respect to PCPs set forth in this Section and **Appendix N**.

2) The Contractor shall provide any information and reports related to the Contractor's ability to meet the requirements set forth in in this section and **Appendix N** for the Service Areas identified by the Contractor and for all other Services Areas for which the Contractor has contracted with EOHHS to serve MassHealth Members as requested by EOHHS.

3) Based on such information, or other information available to EOHHS, and if the Contractor is otherwise in compliance with applicable Contract requirements, EOHHS may, in its discretion, identify Service Areas for which it has determined:

a) That it will be imminently infeasible for the Contractor to maintain a provider network consistent with the requirements in in this section and **Appendix N** resulting from rare circumstances (such as, but not limited to, lack of availability of PCPs to join the Contractor's provider network and the increase in the number of Enrollees in the Contractor's plan compared to the increase in the number of Enrollees across MassHealth managed care plans over a set period); and

b) It is in EOHHS's interest for the Contractor to serve such Service Areas.

4) If EOHHS notifies the Contractor of any Service Areas meeting the criteria in subsection (3) above, the Contractor shall inform EOHHS of whether it wishes to continue covering such Service Areas.

a) If the Contractor wishes to continue to cover such a Service Area identified by EOHHS for any Enrollees, the Contractor shall demonstrate to EOHHS's satisfaction that it is able to meet a minimum threshold with respect to the time and distance requirement set forth in in this section and **Appendix N** for such Service Area. If it is able to demonstrate such compliance to EOHHS's satisfaction, the Contractor may cover such Service Area with EOHHS's approval as described below and the Contractor shall be responsible for meeting all Contract requirements in such Service Area; provided, however that:

(i) EOHHS may temporarily restrict auto-assignment in

such Service Area;

(ii) EOHHS may temporarily restrict new enrollment in such Service Area subject to EOHHS's determination that such restriction complies with all applicable requirements (e.g., suitable plan choices for Members);

(iii) Covering the Service Area is subject to all required federal approvals; and

(iv) The Contractor shall develop a workplan for EOHHS's approval. Such workplan may include, as directed by EOHHS efforts to expand its PCP network; efforts to monitor PCP access; a timeline for reopening enrollment to new Enrollees (if applicable); a timeline for meeting time and distance standards and addressing grievances or concerns from Enrollees; and any other items specified by EOHHS.

b) If the Contractor does not wish to cover such a Service Area identified by EOHHS, EOHHS will not enroll Members with the Contractor for such Service Areas and the Contractor shall not be responsible for meeting Contract requirements in such Service Area.

5) The Contractor shall submit its preference described above as to whether to continue to cover a Service Area in writing to EOHHS. EOHHS shall approve, disapprove, or require modifications based on its reasonable judgment as to whether such preferences are reasonable and in EOHHS's interest. The Contractor shall promptly and diligently work with EOHHS to implement such preferences as approved by EOHHS. In the case of no longer covering a Service Area, such work shall include, but may not be limited to,

a) working collaboratively with EOHHS as EOHHS disenrolls existing Enrollees from the Contractor's plan, including but not limited to complying with continuity of care requirements, and

b) executing in a timely manner any amendment to this Contract to remove such Service Area from the list of Service Areas for which the Contractor has contracted with EOHHS to serve MassHealth Members.

6) At any time, EOHHS may determine that circumstances have changed such that allowing the Contractor to cover a Service Area pursuant to this section is no longer appropriate or necessary. In such cases, EOHHS will provide the Contractor with reasonable notice to come into

compliance with the requirements in this Section and **Appendix N** and all other Contract requirements for such Service Area by a specified date and enroll Members with the Contractor in such Service Area in accordance with the readiness requirements set forth in **Section 2.2.B.f-g**. (For the purposes of such section, the Contract Operational Start Date shall be the abovementioned specified date in this Section.)

2. Pharmacy

   a. The Contractor shall develop and maintain a network of retail pharmacies that ensure prescription drug coverage and availability throughout the Service Area seven days a week.

   b. The Contractor shall include in its Network a sufficient number of pharmacies to meet the time and distance requirements set forth in **Appendix N**.

3. Other Physical Health Specialty Providers

   a. The Contractor shall include in its Network a sufficient number of specialty Providers to meet the time and distance requirements set forth in **Appendix N**.

   b. For all other specialty provider types not listed in **Appendix N**, the Contractor shall include in its Network a sufficient number of Providers to ensure access in accordance with the usual and customary community standards for accessing care. Usual and customary community standards shall be equal to or better than such access in the Primary Care Clinician Plan.

   c. Obstetrician/Gynecologists

      1) In addition to the requirements set forth at **Appendix N**, the Contractor shall maintain an Obstetrician/Gynecologist ratio, throughout the Service Area, of one to 500 Enrollees who may need such care, including but not limited to female Enrollees aged 10 and older and other transgender and gender diverse individuals who need Obstetric and/or Gynecologic care. EOHHS may approve a waiver of such ratio in accordance with federal law.

      2) When feasible, Enrollees shall have a choice of two Obstetrician/Gynecologists.

4. The Contractor shall report to EOHHS in accordance with **Appendix A**, the following:

      1) A specialist-to-Enrollee ratio report showing the number of each specialist by specialty type per the number of Enrollees;

      2) As specified by EOHHS, a geographic access report for high volume specialty provider types based on utilization, demonstrating access by

geography; and

5. Behavioral Health Services (as listed in **Appendix C**)

   a. The Contractor shall include in its Network a sufficient number of Behavioral Health Providers to meet the time and distance requirements set forth in **Appendix N** to the extent qualified, willing providers are available.

   b. In addition to the Availability requirements set forth in **Appendix N**, the Contractor shall include in its Network:

      1) At least one Network Provider of each Behavioral Health Covered Service set forth in **Appendix C** in every Service Area of the state served by the Contractor or, as determined by EOHHS, to the extent that qualified, interested Providers are available; and

      2) Providers set forth in **Appendix G, Exhibit 1** in accordance with the geographic distribution set forth in such appendix, as updated by EOHHS from time to time, including but not limited to providers of ESP Services;

   c. The Contractor shall monitor its Providers as it relates to creating waiting lists for Enrollees seeking outpatient Behavioral Health Services, as described in **Appendix C**.

      1) If the Contractor becomes aware that one or more Providers have created a waiting list, the Contractor shall create a plan to identify such Providers and to assist such Providers with reducing such waiting lists, with the goal of eliminating such waiting lists. Such assistance shall include, but may not be limited to, assisting impacted Enrollees in finding an appropriate alternative Provider.

      2) The Contractor shall ensure that Providers who utilize waiting lists comply with all applicable anti-discrimination laws and refer impacted Enrollees to other qualified Providers who do not have waiting lists as appropriate.

6. Exceptions to Availability Standards

   The Contractor shall document and submit to EOHHS, in writing, a request for an exception and justification for any such exception to the standards specified in this section. Such justification shall be based on the usual and customary community standards for accessing care. Usual and customary community standards shall be equal to or better than such access in the Primary Care Clinician Plan.

D. Access for Non-English Speaking Enrollees

The Contractor shall ensure that non-English speaking Enrollees have a choice of at least two PCPs, and at least two Behavioral Health Providers within each Behavioral Health ACO Covered Service category set forth in **Appendix C**, in Prevalent Languages in the Service Area provided that such provider capacity exists within the Service Area.

E. Direct Access to Specialists

For Enrollees including, but not limited to, Enrollees with Special Health Care Needs, determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.

F. Certification to EOHHS

The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with 42 CFR 438.207(d). Such information shall include a certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding network adequacy, as well as any supporting documentation specified by EOHHS to demonstrate the accuracy of such certification.

Section 2.11 Enrollee Services

The Contractor shall:

A. Written Materials

Unless otherwise provided in this Contract, ensure that all written materials provided by the Contractor to Enrollees and Members are:

1. Are Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor's membership;
2. Are produced in a manner, format, and language that may be easily understood by persons with limited English proficiency;
3. Are translated into Prevalent Languages of the Contractor's membership;
4. Are made available in Alternative Formats upon request free-of-charge, including video and audio; and information is provided about how to access written materials in those formats and about the availability of free auxiliary aids and services, including, at a minimum, services for Enrollees with disabilities;
5. Are mailed with a language card that indicates that the enclosed materials are important and shall be translated immediately, and that provides information on how the Enrollee may obtain help with getting the materials translated;
6. Use a font size no smaller than 12 point;

7. Include a large print tagline (i.e., no smaller than 18 point font size); and

8. Be “co-branded” to include both the Contractor’s and ACO Partner’s names or logos.

B. Electronic Information

Not provide Enrollee information required by this Contract electronically unless all of the following are met:

1. The format is readily accessible;

2. The information is placed in a location on the Contractor’s web site that is prominent and readily accessible;

3. The information is provided in an electronic form which can be electronically retained and printed;

4. The information is consistent with the content and language requirements of this Contract; and

5. The Enrollee is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days.

C. Information Required

1. Provide Enrollee Information to Enrollees and, upon request, to Members, including all the items detailed in **Section 2.4.B.2.f**. The Contractor shall clearly identify differences in such information as it applies to the different Coverage Types which may be achieved by providing different Enrollee Information for Enrollees based on Coverage Types, or by providing separate inserts for the different populations. The Contractor shall make available written translations of Enrollee Information in Prevalent Languages and inform Enrollees how to obtain translated Enrollee Information or how to obtain an oral translation in a language other than a Prevalent Language. The Contractor shall make available Enrollee Information in Alternative Formats and inform Enrollees how to obtain such Enrollee Information;

2. Provide Enrollee Information as follows:

   a. Mail a printed copy of the information to the Enrollee’s mailing address;

   b. Provide the information by email after obtaining the Enrollee’s agreement to receive information by email;

   c. Post the information on the Contractor’s website and advise the Enrollees in paper or electronic form that the information is available on the Internet and include the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided free auxiliary aids and services upon request; or

d. Provide the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

3. As further specified by EOHHS, the Contractor shall provide and maintain its Enrollee handbook, Provider directory, and the MassHealth Drug List on its website in a reasonably easy to find location.

D. Handbooks

As directed by EOHHS, update and distribute, in the normal course of business, Enrollee handbooks including the ACO Covered Services list. As further directed by EOHHS, such Enrollee handbooks shall conform to a model provided by EOHHS;

E. Education Material

Update Enrollee and Provider education materials that are provided to individuals under age 21, or Providers of services to individuals under age 21, and update and distribute such materials to describe EPSDT and CBHI services as further directed by EOHHS;

F. Enrollee Services Department

1. Maintain an Enrollee services department to assist Enrollees, Enrollees' family members or guardians, and other interested parties in learning about and obtaining services under this Contract;

2. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff for the Enrollee services department;

3. Ensure that Enrollee services department staff have access to:

a. The Contractor's Enrollee database;

b. The Eligibility Verification System (EVS); and

c. An electronic Provider directory that includes, but is not limited to, the information specified in **Section 2.8.E** of this Contract;

G. Enrollee Services Telephone Line

Operate a toll-free Enrollee services telephone line a minimum of nine hours per day during normal business hours, Monday through Friday, which shall:

1. Have at least 90% of calls answered by a trained customer service department representative (non-recorded voice), within 30 seconds or less as reported in accordance with **Appendix A**;

2. Have less than a 5% abandoned call rate;

3. Make oral interpretation services available free-of-charge to Members and Enrollees in all non-English languages spoken by Members and Enrollees; and;

4. Maintain the availability of services free-of-charge, such as TTY services or comparable services for the deaf and hard of hearing;

H. Information for Enrollees and Potential Enrollees

Ensure that customer service department representatives shall, upon request, make available to Enrollees and Potential Enrollees in the Contractor's Plan information concerning the following:

1. The identity, locations, qualifications, and availability of Providers;

2. The rights and responsibilities of Enrollees including, but not limited to, those Enrollee rights described in **Section 5.1.L**;

3. The procedures available to an Enrollee and Provider(s) to challenge or appeal the failure of the Contractor to provide a covered service and to appeal any Adverse Action as explained in the Enrollee handbook;

4. How Enrollees and Potential Enrollees may access oral interpretation services free-of-charge in any non-English language spoken by Enrollees and Potential Enrollees;

5. How Enrollees and Potential Enrollees may access written materials in Prevalent Languages and Alternative Formats;

6. All ACO Covered Services and Non-ACO Covered Services that are available to Enrollees either directly or through referral or authorization; and

7. Additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of the Plan.

I. Miscellaneous Customer Service Requirements

Ensure that its customer services representatives who are assigned to:

1. Respond to MassHealth specific Inquiries:

   a. Understand and have a working knowledge of the Contract between EOHHS and the Contractor;

   b. Answer Enrollee Inquiries, including those related to enrollment status and accessing care;

   c. Are trained in Grievance, Internal Appeals, and BOH Appeals processes and procedures, as specified in **Section 2.13**;

   d. Refer Enrollee Inquiries that are of a clinical nature, but non-behavioral health, to clinical staff with the appropriate clinical expertise to adequately respond;

e. Refer Enrollee Inquiries related to Behavioral Health to the Contractor's behavioral health clinical staff except where said Inquiries are solely administrative in content. For the purposes of this Section, examples of administrative Inquiries shall include requests for general information regarding particular Behavioral Health Providers such as their participation as Network Providers, their address or their hours of operation, and shall exclude any questions that require judgment by a Behavioral Health clinical professional to provide an adequate response; and

f. Have the ability to answer Enrollee Inquiries in the Enrollee's primary language free-of-charge through an alternative language device or interpreter;

2. Respond to questions from Providers are informed about the requirements and process for applicable Providers to become trained and certified in administering the CANS Tool and can respond to questions from Providers about these requirements and processes. The Contractor shall provide training to its newly-hired and current customer service representatives about who, when, where and how Providers must be CANS trained and certified and provide refresher trainings as directed by EOHHS or as the Contractor determines is necessary; and

3. Respond to Enrollee inquiries are informed about the CANS and can respond to questions from Enrollees about the CANS. The Contractor shall provide training to its newly-hired and current customer service representatives about the CANS and how it is generally used in Behavioral Health Clinical Assessments and as part of the Discharge Planning process from Inpatient Mental Health Services and Community Based Acute Treatment Services;

J. Customer Service Training

Establish a schedule of intensive training for newly-hired and current customer service representatives about:

1. When, where and how Enrollees may obtain EPSDT screenings, diagnosis and treatment services; and

2. The CBHI and when those services are available. Such trainings shall include the following and any other activities that are directed by EOHHS:

a. A written curriculum, which shall be prior-approved by EOHHS and subject to modification in whole or in part at the discretion of EOHHS; and

b. Refresher trainings that are provided as directed by EOHHS, or as the Contractor determines necessary, to assure that Enrollees receive accurate information about EPSDT and the CBHI;

K. My Account Page Application

With Enrollee consent, assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page Application on the Virtual Gateway, as follows:

1. If the Contractor learns from an Enrollee or an Authorized Representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the Contractor obtains demographic information from the Enrollee or Authorized Representative, the Contractor shall provide such information to EOHHS by entering it into the Change Form via the My Account Page Application on the Virtual Gateway, after obtaining the Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

2. Prior to entering such demographic information, the Contractor shall advise the Enrollee as follows: "Thank you for this change of address [phone] information. You are required to provide updated address [phone] information to MassHealth. We would like to help you to do that so, with your oral permission, we will forward this information to MassHealth. You may also provide MassHealth with information about your race or ethnicity. This is not required, but it will help MassHealth to improve Member services. You have provided us with this information. If you do not object, we will pass that information on to MassHealth for you."

3. If the Contractor receives updated demographic information from a third party, such as a Provider, a vendor hired to obtain demographic information, or through the post office, the Contractor shall confirm the new demographic information with the Enrollee, and obtain the Enrollee's permission, prior to submitting the information to EOHHS on the Change Form.

4. The Contractor shall ensure that all appropriate staff entering this information have submitted the documentation necessary to complete this function on the Virtual Gateway and completed any necessary Virtual Gateway training requirements.

L. Additional Information Requirement

Provide additional information that may be needed for Enrollees and Potential Enrollees to fully understand the requirements and benefits of the Contractor's Plan as directed by EOHHS;

M. Definitions

Adopt definitions as specified by EOHHS, consistent with 42 CFR 438.10(c)(4)(i).

N. Notices to Enrollees

As further directed by EOHHS, the Contractor's notices to Enrollees shall conform to models provided by EOHHS.

Section 2.12 Marketing Activity Requirements

A. General Requirements

In conducting any Marketing activities described herein, the Contractor shall:

1. Ensure that all Marketing Materials regarding the Contractor's Plan clearly state that information regarding all MassHealth Managed Care enrollment options including, but not limited to, the Contractor's Plan, are available from the MassHealth Customer Service Center. The Contractor shall ensure that all written Marketing Materials prominently display the telephone number and hours of operation of the MassHealth Customer Service Center in the same font size as the same information for the Contractor's customer service center. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by the Contractor;

2. Comply with all applicable information requirements set forth in 42 CFR 438.10 when conducting Marketing activities and preparing Marketing Materials;

3. Submit all Marketing Materials to EOHHS for approval prior to distribution. The Contractor shall submit Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible;

4. Comply with any requirement imposed by EOHHS pursuant to **Section 3.5** of this Contract;

5. Distribute and/or publish Marketing Materials throughout the Contractor's Service Area(s), as indicated in **Appendix F**, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials (1) to a part of the Contractor's Service Area(s) outlined in **Appendix F**; or (2) where the campaign relates to a local event (such as a health fair) or to a single Provider (such as a hospital or clinic), to a certain zip code or zip codes; and

6. Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval.

B. Permissible Marketing Activities

The Contractor may engage in only the following Marketing activities, in accordance with the requirements stated in **Section 2.12.A** above.

1. A health fair or community activity sponsored by the Contractor provided that the Contractor shall notify all MassHealth-contracted Accountable Care Partnership Plans or MCOs within the geographic region of their ability to participate. Such notification shall be in writing and shall be made as soon as reasonably possible prior to the date of the event. If other MassHealth-contracted Accountable Care Partnership Plans or MCOs choose to participate in a Contractor's sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted Accountable Care Partnership Plans and

MCOs. The Contractor may conduct or participate in Marketing at Contractor or non-Contractor sponsored health fairs and other community activities only if:

a. Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

b. Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the Contractor's Plan.

2. The Contractor may participate in Health Benefit Fairs sponsored by EOHHS. Such Health Benefit Fairs will be held in accordance with **Section 3.4**.

3. The Contractor may market the Contractor's Plan to Members in accordance with **Section 2.12.A** above, by distributing and/or publishing Marketing Materials throughout the Contractor's Service Area(s), as indicated in **Appendix F** or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

a. Posting written Marketing Materials that have been pre-approved by EOHHS at Provider sites and other locations; and posting written promotional Marketing Materials at Network Provider and other sites throughout the Contractor's Service Area;

b. Initiating mailing campaigns that have been pre-approved by EOHHS, where the Contractor distributes Marketing Materials by mail; and

c. Television, radio, newspaper, website postings, and other audio or visual advertising.

C. Prohibitions on Marketing and Enrollment Activities

The Contractor shall **not**:

1. Distribute any Marketing Material that has not been pre-approved by EOHHS;

2. Distribute any Marketing Material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the Marketing Material, including but not limited to, any assertion or statement, whether written or oral, that:

a. The recipient of the Marketing Material must enroll in the Contractor's Plan in order to obtain benefits or in order to not lose benefits; or

b. The Contractor is endorsed by CMS, the federal or state government or similar entity;

3. Seek to influence a Member's enrollment in the Contractor's Plan in conjunction with

the sale or offering of any private or non-health insurance products (e.g., life insurance);

4. Seek to influence a Member's enrollment into the Contractor's Plan in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts;

5. Directly or indirectly, engage in door-to-door, telephonic, email, texting, or any other Cold-call Marketing activities;

6. Engage in any Marketing activities which could mislead, confuse or defraud Members or Enrollees, or misrepresent MassHealth, EOHHS, the Contractor or CMS;

7. Conduct any Provider site Marketing, except as provided in **Sections 2.12.A.4 and 2.12.B.3.a**;

8. Incorporate any costs associated with Marketing or Marketing incentives, or Non-Medical Programs or Services in the report specified in **Appendix A**; or

9. Engage in Marketing activities which target Members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

D. Marketing Plan and Schedules

1. The Contractor shall make available to EOHHS, upon request, for review and approval:

   a. A comprehensive Marketing Plan including proposed Marketing approaches to groups and individuals in the Contractor's Service Area(s); and

   b. Current schedules of all Marketing activities, including the methods, modes, and media through which Marketing Materials will be distributed.

2. As requested by EOHHS, the Contractor shall present its Marketing Plan in person to EOHHS for review and approval.

3. As requested by EOHHS, the Contractor shall submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its Marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud Members or the state.

E. Information to Enrollees

Nothing herein shall be deemed to prohibit the Contractor from providing non-Marketing information to Enrollees consistent with this Contract, regarding new services, personnel, Enrollee education materials, Care Management programs and Provider sites.

F. MassHealth Benefit Request and Eligibility Redetermination Assistance

As directed by EOHHS, the Contractor or Provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:

1. Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants;

2. Assist MassHealth applicants in completing and submitting MBRs;

3. Offer to assist Enrollees with completion of the annual ERV form; and

4. Refer MassHealth applicants to the MassHealth Customer Service Center.

Section 2.13 Inquiries, Ombudsman Services, Grievances, Internal Appeals and BOH Appeals

A. General Requirements

The Contractor shall:

1. Maintain written policies and procedures for:

   a. The receipt and timely resolution of Grievances and Internal Appeals, as further described in **Section 2.13.B** below. Such policies and procedures shall be approved by EOHHS; and

   b. The receipt and timely resolution of Inquiries, where timely resolution means responding to the Inquiry at the time it is raised to the extent possible or, if not possible, acknowledging the Inquiry within 1 business day and making best efforts to resolve the Inquiry within 1 business day of the initial Inquiry. Such policies and procedures shall be approved by EOHHS;

2. Review the Inquiry, Grievance and Internal Appeals policies and procedures established pursuant to **Section 2.13.A.1** above, at least annually to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS;

3. Create and maintain records of Inquiries, Grievances, Internal Appeals, and BOH Appeals, using the health information system(s) specified in **Section 2.15.E**, to document:

   a. The type and nature of each Inquiry, Grievance, Internal Appeal, and BOH Appeal;

   b. How the Contractor disposed of or resolved each Grievance, Internal Appeal, or BOH Appeal; and

   c. What, if any, corrective action the Contractor took;

4. Report to EOHHS on Inquiries, Grievances, Internal Appeals and BOH Appeals, as described in **Appendix A** in a form and format specified by EOHHS, including but not limited to a summary, the number of Appeals per 1,000 Enrollees, and the number of

Grievances per 1,000 Enrollees.

5. Assure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any Inquiry, Grievance, Internal Appeal, or BOH Appeal;

6. Provide Enrollees with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes, as specified in **Section 2.4.B.2.f.21**; and

7. Provide the information specified in **Section 2.4.B.2.f.21** to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor.

8. In addition to other obligations set forth in this Contract related to Ombudsman Services, the Contractor shall support Enrollee access to, and work with, the Ombudsman to address Enrollee and Potential Enrollee requests for information, issues, or concerns related to the MassHealth ACO Program, by:

    a. Providing Enrollees with education and information about the availability of Ombudsman services including when Enrollees contact the Contractor with requests for information, issues, concerns, complaints, Grievances, Internal Appeals or BOH Appeals;

    b. Communicating and cooperating with Ombudsman staff as needed for such staff to address Enrollee or Potential Enrollee requests for information, issues, or concerns related to the Contractor, including:

        1) Providing Ombudsman staff, with the Enrollee's appropriate permission, with access to records related to the Enrollee; and

        2) Engaging in ongoing communication and cooperation with Ombudsman staff until the Enrollee's or Potential Enrollee's request or concern is addressed or resolved, as appropriate, including but not limited to providing updates on progress made towards resolution.

B. Grievances and Internal Appeals

The Contractor shall maintain written policies and procedures for the filing by Enrollees or Appeals Representatives and the receipt, timely resolution, and documentation by the Contractor of any and all Grievances and Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR Part 438, Subpart F. (For purposes of this Section, in cases where a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment, or may appoint an Appeal Representative to represent them, without parental/guardian consent.)

1. General Requirements

    a. The Contractor shall put in place a standardized process that includes:

1) A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;

2) A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 2.13.B.2.C** and **2.13.B.4** below; and

3) A means for expedited resolution of Internal Appeals, as further specified in **Section 2.13.B.4.d**, when the Contractor determines (for a request from the Enrollee) or a Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution, in accordance with **Section 2.13.B.4.a**, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

b. The Contractor shall put in a place a mechanism to:

1) Accept Grievances filed either orally or in writing; and

2) Accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.13.B.2**, provided that if an Internal Appeal is filed orally, the Contractor shall not require the Enrollee to submit a written, signed Internal Appeal form subsequent to the Enrollee's oral request for an appeal. Internal Appeals filed later than 60 days from the notice of Adverse Action may be rejected as untimely.

c. The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Enrollees and, if an Appeals Representative filed the Grievance or Internal Appeal, to the Appeals Representative and the Enrollee within 1 business day of receipt by the Contractor.

d. The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.13.B.2**.

2. 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.

a. The notice shall meet the language and format requirements specified in **Section 2.11.A**.

b. The notice shall explain the following:

1) The Adverse Action the Contractor has taken or intends to take;

2) The reason(s) for the Adverse Action, including the right of the Enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Action, such as medical necessity criteria and processes, strategies, and standards related to the Adverse Action;

3) The Enrollee's right to file an Internal Appeal or to designate an Appeal Representative to file an Internal Appeal on behalf of the Enrollee, including exhausting the appeal process and right to file an appeal with the Board of Hearings;

4) The procedures for an Enrollee to exercise his/her right to file an Internal Appeal;

5) The circumstances under which expedited resolution of an Internal Appeal is available and how to request it;

6) That the Contractor will provide the Enrollee Continuing Services, if applicable, pending resolution of the review of an Internal Appeal if the Enrollee submits the request for the review within 10 days of the Adverse Action;

7) That the Contractor will provide the Enrollee Continuing Services, if applicable, pending resolution of a BOH Appeal if the Enrollee submits the request for the BOH Appeal within 10 days of receipt of notice of the Final Internal Appeal Decision, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services.

c. The notice shall be mailed within the following timeframes:

1) For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action in accordance with 42 CFR 431.211, except as provided in 42 CFR 431.213. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to 5 calendar days before the Date of Action if the Contractor has facts indicating that action shall be taken because of probable fraud by the Enrollee and the facts have been verified, if possible, through secondary sources.

2) 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:

a) Failure to follow prior authorization procedures;

b) Failure to follow referral rules; and

c) Failure to file a timely claim.

3) For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.7.C.6.a**, as expeditiously as the Enrollee's health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

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) that:

(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 shall:

(i) Give the Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

(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.

4) For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section**

2.7.C.6.b, as expeditiously as the Enrollee's health requires but no later than 72 hours after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

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 shall do the following:

(i) Give the Enrollee written notice of the reason for the extension and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

(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.

5) For standard or expedited service authorization decisions not reached within the timeframes specified in **Sections 2.7.C.6.a** and **b**, whichever is applicable, on the day that such timeframes expire.

6) When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 2.10.B**, within one business day upon notification by the Enrollee or Provider that one of the access standards in **Section 2.10.B** was not met.

3. Handling of Grievances and Internal Appeals

In handling Grievances and Internal Appeals, the Contractor shall:

a. Inform Enrollees of the Grievance, Internal Appeal, and BOH Appeal procedures, as specified in **Section 2.4.B.2.g.21**.

b. Give reasonable assistance to Enrollees in completing forms and following procedures applicable to Grievances and Internal Appeals, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

c. Provide notice of Adverse Actions as specified in **Section 2.13.B.2**;

d. Accept Grievances and Internal Appeals filed in accordance with **Section 2.13.B.1.b**;

e. Send written acknowledgement of the receipt of each Grievance or Internal Appeal to the Enrollee and Appeal Representative within one business day of receipt by the Contractor;

f. Ensure that the individuals who make decisions on Grievances and Internal Appeals:

1) Are individuals who were not involved in any previous level of review or decision-making, and are not the subordinates of any such individuals; and

2) Take into account all comments, documents, records, and other information submitted by the Enrollee or the Appeal Representative without regard to whether such information was submitted or considered in the Adverse Action determination.

g. Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

1) An appeal of a denial that is based on lack of medical necessity;

2) Grievances regarding the denial of an Enrollee's request that an Internal Appeal be expedited, as specified in **Section 2.13.B.4.d.3**; and

3) Grievances regarding clinical issues;

h. Ensure that the following special requirements are applied to Internal Appeals:

1) The Contractor shall offer one level of review of an Adverse Action for Internal Appeals;

2) All reviews of Internal Appeals shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action;

3) The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and shall not require the Enrollee or an Appeal Representative to confirm such oral requests in writing as specified in **Section 2.13.B.1.b.2**;

4) The Contractor shall provide a reasonable opportunity for the Enrollee or an Appeal Representative to present evidence and allegations of fact or law, in person as well as in writing, and shall inform the Enrollee or an Appeal Representative about the limited time available for this opportunity in the case of expedited Internal Appeals;

5) The Contractor shall provide the Enrollee and an Appeal Representative, before and during the Internal Appeals process, the Enrollee's case file, including medical records, and any other documentation and records considered, relied upon, or generated during the Internal Appeals process. This information shall be provided free of charge and sufficiently in advance of the applicable resolution timeframe; and

6) The Contractor shall include, as parties to the Internal Appeal, the Enrollee and Appeal Representative or the legal representative of a deceased Enrollee's estate;

4. Resolution and Notification of Grievances and Internal Appeals

The Contractor shall:

a. 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:

1) For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Enrollee or the Enrollee's Authorized Appeal Representative, unless this timeframe is extended in accordance with **Section 2.13.B.4.b**;

2) For standard resolution of Internal Appeals and notice to the affected

parties, no more than 30 calendar days from the date the Contractor received either in writing or orally, whichever comes first, the Enrollee request for an Internal Appeal unless this timeframe is extended under **Section 2.13.B.4.b**; and

3) For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours from the date the Contractor received the expedited Internal Appeal unless this timeframe is extended under **Section 2.13.B.4.b**. The Contractor shall process the expedited Internal Appeal even if a Provider is allegedly serving as the Enrollee's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form. The Contractor shall require that the Provider submit a signed Authorized Appeal Representative form to the Contractor as documentation that the Enrollee did in fact authorize the Provider to file the expedited Internal Appeal on the Enrollee's behalf, as long as the expedited Internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

b. Extend the timeframes in **Section 2.13.B.4.a.1-3** by up to 14 calendar days if:

1) The Enrollee or Appeal Representative requests the extension, or

2) The Contractor can justify (to EOHHS upon request) that:

a) The extension is in the Enrollee's interest; and

b) There is a need for additional information where:

(i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

(ii) Such outstanding information is reasonably expected to be received within 14 calendar days;

3) For any extension not requested by the Enrollee, the Contractor shall:

a) Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the delay;

b) Provide the Enrollee and Appeal Representative written notice of the reason for the delay within 2 calendar days. Such notice shall include the reason for the extension of the timeframe and the Enrollee's right to file a grievance; and

c) Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date of extension

expires.

c. Provide notice in accordance with **Section 2.13.B.4.a** regarding the disposition of a Grievance or the resolution of a standard Internal Appeal or an expedited Internal Appeal as follows:

1) All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10. For notices of an expedited Internal Appeal resolution, the Contractor shall also make reasonable efforts to provide oral notice to the Enrollee; and

2) The notice shall contain, at a minimum, the following:

a) The results of the resolution process and the effective date of the Internal Appeal decision;

b) For Internal Appeals not resolved wholly in favor of the Enrollee:

(i) The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing Form; and

(ii) That the Enrollee will receive Continuing Services, if applicable, while the BOH Appeal is pending if the Enrollee submits the appeal request to the BOH within 10 days of the Adverse Action, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services; and

d. Resolve expedited Internal Appeals as follows:

1) The Contractor shall resolve Internal Appeals expeditiously in accordance with the timeframe specified in **Section 2.13.B.4.a.3** when the Contractor determines (with respect to an Enrollee's request for expedited resolution) or a Provider indicates (in making the request for expedited resolution on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall process the expedited Internal Appeal even if the Provider is allegedly serving as the Enrollee's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form.

2) The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support an Enrollee's Internal

Appeal.

3) If the Contractor denies an Enrollee's request for an expedited resolution of an Internal Appeal, the Contractor shall:

a) Transfer the Internal Appeal to the timeframe for standard resolution in **Section 2.13.B.4.a.2** above;

b) Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the denial, and follow-up within two calendar days with a written notice. Such notice shall include the Enrollee's right to file a Grievance; and

c) Resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the applicable deadlines set forth in this Contract.

4) The Contractor shall not deny a Provider's request (on an Enrollee's behalf) that an Internal Appeal be expedited unless the Contractor determines that the Provider's request is unrelated to the Enrollee's health condition.

C. Board of Hearings

The Contractor shall:

1. Require Enrollees and their Appeal Representatives to exhaust the Contractor's Internal Appeals process before filing an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if either of the following conditions is met:

a. The Contractor has issued a decision following its review of the Adverse Action; or

b. The Contractor fails to act within the timeframes for reviewing Internal Appeals or fail to satisfy applicable notice requirements.

2. Include with any notice following the resolution of a standard Internal Appeal or an expedited Internal Appeal, as specified in **Section 2.13.B.4.c**, any and all instructive materials and forms provided to the Contractor by EOHHS that are required for the Enrollee to request a BOH Appeal; and

3. Notify Enrollees that:

a. Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services; and

b. It is the Enrollee's or the Appeal Representative's responsibility to submit any

request for a BOH Appeal to the BOH and to ensure that the BOH receives the request within the time limits, as specified in 130 CMR 610.015(B)(7), specifically 120 days after the Enrollee's receipt of the Contractor's Final Internal Appeal Decision where the Contractor has reached a decision wholly or partially adverse to the Enrollee, provided however that if the Contractor did not resolve the Enrollee's Internal Appeal within the time frames specified in this Contract and described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that Internal Appeal has expired.

4. Be a party to the BOH Appeal, along with the Enrollee and their representative or the representative of a deceased Enrollee's estate.

D. Additional Requirements

The Contractor shall:

1. For all Final Internal Appeal Decisions upholding an Adverse Action, in whole or in part, the Contractor shall provide EOHHS upon request, within one business day of issuing the decision, with a copy of the decision sent to the Enrollee and Appeal Representative, as well as all other materials associated with such Appeal, to assist in EOHHS's review of the Contractor's determination. This requirement shall also apply to situations when the Contractor fails to act within the timeframes for reviewing Internal Appeals. For decisions involving Behavioral Health Services, EOHHS may consult with the Deputy Commissioner of the Department of Mental Health in its review of the Contractor's decision;

2. Upon learning of a hearing scheduled on a BOH Appeal concerning such a Final Internal Appeal Decision, notify EOHHS immediately and include the names of the Contractor's clinical and other staff who will be attending the BOH hearing;

3. Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;

4. Submit all applicable documentation to the BOH, EOHHS, the Enrollee and the designated Appeal Representative, if any, within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of the notice of Adverse Action, any documents relied upon by the Contractor in rendering the decision resolving the Internal Appeal, and any and all documents that will be relied upon at hearing;

5. Make best efforts to ensure that a Provider, acting as an Appeal Representative, submits all applicable documentation to the BOH, the Enrollee and the Contractor within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be

relied upon at the hearing;

6. Comply with and implement the decisions of the BOH;

7. In the event that the Enrollee appeals a decision of the BOH, comply with and implement the decisions of any court of competent jurisdiction; and

8. Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:

    a. Determine whether each Enrollee who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 2.13.C.1**;

    b. If requested by the Enrollee, assist the Enrollee with completing a request for a BOH Appeal;

    c. Receive notice from the BOH that an Enrollee has requested a BOH Appeal, immediately notify EOHHS, and track the status of all pending BOH Appeals;

    d. Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH Appeal was timely received, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Service;

    e. Instruct Enrollees for whom an Adjustment has been made about the process of informing the BOH in writing of all Adjustments and, upon request, assist the Enrollee with this requirement, as needed;

    f. Ensure that the case folder and/or pertinent data screens are physically present at each hearing;

    g. Ensure that appropriate Contractor staff attend BOH hearings;

    h. Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;

    i. Upon notification by BOH of a decision, notify EOHHS immediately;

    j. Ensure that the Contractor implements BOH decisions upon receipt;

    k. Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;

    l. Coordinate with the BOH, as directed by EOHHS; and

    m. Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.

9. Provide information about the Contractor's grievances and appeals policies to all Providers and Material Subcontractors at the time the Contractor and these entities

enter into a contract; and

10. Maintain records of Grievances and Appeals in a manner accessible to EOHHS, available to CMS upon request, and that contain, at a minimum, the following information:

    a. A general description of the reason for the Appeal or Grievance;

    b. The date received, the date of each review, and, if applicable, the date of each review meeting;

    c. Resolution of the Appeal or Grievance, and date of resolution; and

    d. Name of the Enrollee for whom the Appeal or Grievance was filed.

E. Continuing Services

The Contractor shall:

1. Comply with the provisions of 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Enrollee specifically indicates that he or she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service;

2. Provide Continuing Services until one of the following occurs:

    a. The Enrollee withdraws the Internal Appeal or BOH Appeal; or

    b. The BOH issues a decision adverse to the Enrollee;

3. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Internal Appeal or BOH Appeal were pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination; and

4. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services and the Enrollee received Continuing Services while the Internal Appeal or BOH Appeal were pending, the Contractor shall pay for such services.

Section 2.14 Quality Management and Quality Improvement

A. Quality Management (QM) and Quality Improvement (QI) Principles

The Contractor shall:

1. Deliver quality care that enables Enrollees to stay healthy, get better and, if necessary, manage a chronic illness or disability. Quality care refers to:

a. Clinical quality of physical health care;

b. Clinical quality of behavioral health care focusing on recovery, resiliency and rehabilitation;

c. Access and availability of primary and specialty health care Providers and services;

d. Continuity and coordination of care across settings (including Community Partners), and transitions in care; and

e. Enrollee experience with respect to clinical quality, access and availability and Cultural and Linguistic Competence of health care and services, and continuity and coordination of care;

2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

a. Quantitative and qualitative data collection and data-driven decision-making;

3. 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;

4. Feedback provided by Enrollees and Providers in the design, planning, and implementation of its Continuous Quality Improvement activities; and

5. Issues identified by the Contractor or EOHHS; and

6. 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, robust QM/QI organizational and program structure that supports the application of the principles of Continuous Quality Improvement to all aspects of the Contractor's service delivery system. The QM/QI program shall be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QM/QI organizational and program structure shall comply with all applicable provisions of 42 CFR Part 438, including Subparts D and E, Quality Assessment and Performance Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

The Contractor shall:

1. Establish a clearly defined set of QM/QI functions and responsibilities that are

proportionate to, and adequate for, the planned number and types of QM/QI initiatives and for the completion of QM/QI initiatives in a competent and timely manner;

2. Ensure that such QM/QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, Continuous Quality Improvement to all clinical and non-clinical aspects of the Contractor's service delivery system;

3. Establish internal processes to ensure that the QM activities for Physical Health Services, Behavioral Health Services, and other services as further specified by EOHHS, reflect utilization across the Network and include all of the activities in this **Section 2.14** of this Contract and, in addition, the following elements:

    b. A process to utilize HEDIS and non-HEDIS quality measure results in designing QM/QI activities;

    c. A process to collect race, ethnicity, language and other demographic data elements (e.g., disability status, sexual orientation, gender identity, health-related social needs) to support stratification of HEDIS and non-HEDIS quality measure results to identify disparities and address Health Equity.

    d. A process to utilize HEDIS and non-HEDIS quality measure performance data, including as stratified for the identification of health inequities and to inform design of QM/QI activities to address Health Equity.

    e. 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;

    f. 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;

    g. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

    h. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in Enrollee and family advisory councils;

    i. 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;

4. In collaboration with and as further directed by EOHHS, develop a process to monitor

the quality of services using tools such as the MA DRM (Document Review Measure), or another tool approved by EOHHS, to evaluate the adequacy of medical record keeping for both Intensive Care Coordination and In-Home Therapy Services. The Contractor shall apply the approved quality-assessing tool at least annually on a mix of Intensive Care Coordination and In-Home Therapy Services provided across all of the Contractor's Service Areas. Unless otherwise directed by EOHHS, the Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Contractor's Enrollees who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 10 Enrollees' medical files per Service Area per Contract Year; and

5. Outpatient Behavioral Health Services Monitoring

   In collaboration with and as further directed by EOHHS, the Contractor shall develop a process to monitor the quality of services and evaluate the adequacy of medical record keeping for outpatient Behavioral Health services provided to Enrollees under the age of 21 in accordance with **Appendix C, Exhibit 3**. The Contractor shall utilize a quality assessment tool approved by EOHHS to conduct this review. Annually, the Contractor shall evaluate at least 10% of the Enrollees under the age of 21 who have received outpatient Behavioral Health services during each Contract Year, consisting of a mix of outpatient Behavioral Health Providers, provided however that the Contractor shall not be required to review more than 10 Enrollees' medical files, or another number approved by EOHHS, per Service Area per Contract Year.

6. 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 quality improvement, including but not limited to:

      1) 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;

      2) specific references to Health Related Social Needs and Health Equity.

   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;

7. Submit to EOHHS an annual QM/QI Work Plan that broadly describes the Contractor's annual QI activities under its QI program, in accordance with **Appendix B**, and that includes the following components or other components as directed by EOHHS.

    a. Planned clinical and non-clinical initiatives;

    b. The objectives for planned clinical and non-clinical initiatives;

    c. The short- and long-term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

    d. The individual(s) responsible for each clinical and non-clinical initiative;

    e. Any issues identified by the Contractor, EOHHS, Enrollees, and Providers, and how those issues are tracked and resolved over time; and

    f. The evaluations of clinical and non-clinical initiatives, including Provider profiling activities as described in **Section 2.9.I** and the results of Network Provider satisfaction surveys as described in **Section 2.13.B.3.f** above;

8. 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 Health care, Behavioral Health Care, and other services as further specified by EOHHS, rendered, initiatives focusing on Health Equity and Health Related Social Needs, as well as accomplishments and compliance and/or deficiencies in meeting the previous year's QM/QI Strategic Work Plan;

C. QM/QI Activities

1. Performance Measurement and Improvement Projects

The Contractor shall engage in performance measurement and improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes, Enrollee satisfaction (i.e., member experience), as well as reductions in health inequities. Measurement and improvement projects shall be conducted in accordance with 42 CFR 438.330, and at EOHHS's direction, and shall include, but are not limited to:

    a. Performance Measurement

1) As further specified by EOHHS, the Contractor shall report the results of, or submit to EOHHS data (inclusive of supplemental data) which enables EOHHS to calculate, the Performance Measures set forth in **Appendix Q**, in accordance with 42 CFR 438.330(c). Such Performance Measures may include those specified by CMS in accordance with 42 CFR 438.330(a)(2).

2) At the direction of EOHHS, the Contractor shall support Health Equity initiatives through the stratification of select performance measures or the submission of data elements, which may include but are not limited to factors such as race, ethnicity, language, disability status, age, sexual orientation, gender identity, and Health Related Social Needs.

3) EOHHS may, at its discretion and at any time, identify certain thresholds for Performance Measures or stratified measures which the Contractor shall meet, and the Contractor shall work with EOHHS on such thresholds upon EOHHS request. If EOHHS is concerned with the Contractor's performance on such measures, the Contractor shall discuss such performance with EOHHS, and as further specified by EOHHS:

    a) Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports; and

    b) Provide EOHHS with, and implement as approved by EOHHS, a concrete plan for improving its performance;

4) The Contractor shall demonstrate how to utilize Performance Measure results or stratified measures in designing ongoing QM/QI initiatives to measure, monitor, and improve quality and Health Equity.

b. Clinical Performance Topic Review (CPTR)

1) The Contractor shall contribute to all annual CPTR-related processes, as directed by EOHHS, as follows:

    a) Contribute to EOHHS's process for selecting CPTR measures, as applicable;

    b) In accordance with 42 CFR 438.330(c), collect (or assist EOHHS in collecting) and submit to EOHHS, or EOHHS's designee, in a timely manner, data for CPTR measures selected by EOHHS;

    c) Contribute to EOHHS's data quality assurance processes including, but not limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS; and

d) Contribute to EOHHS processes culminating in the publication of an annual report by EOHHS regarding the individual and aggregate performance of ACOs, MCOs and the PCC Plan with respect to selected CPTR measures.

2) The Contractor shall demonstrate how to utilize CPTR results in designing QM/QI initiatives.

c. Member Surveys

1) The Contractor shall contribute to and participate in all EOHHS member experience survey activities, as directed by EOHHS, as follows:

a) In accordance with 42 CFR 438.330(c), collect (or assist EOHHS in collecting) and submit to EOHHS, or EOHHS's designee, in a timely manner, member experience survey member samples;

b) Contribute, as directed by EOHHS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS; and

c) Contribute, as directed by EOHHS, to processes culminating in the publication of an annual report by EOHHS regarding the individual and aggregate MSS performance of ACOs, MCOs and the PCC Plan.

2) The Contractor shall administer and submit annually to EOHHS the results from the Adult and Pediatric Health Plan Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) that the Contractor submitted to NCQA as part of its accreditation process, including results of any supplemental questions as determined by EOHHS;

3) The Contractor shall make best efforts to utilize member experience survey results in designing QM/QI initiatives.

d. Quality Improvement Goals

The Contractor shall implement and adhere to all processes relating to the Quality Improvement Goals, as directed by EOHHS and as specified in **Appendix B**, as follows:

1) In accordance with 42 CFR 438.330, collect information and data in accordance with Quality Improvement Goal specifications for its Enrollees;

2) Implement well-designed, innovative, targeted, and measurable quality

improvement interventions, in a Culturally and Linguistically Competent manner, to achieve objectives as specified in **Appendix B**;

3) Evaluate the effectiveness of quality improvement interventions incorporating specified targets and measures for performance;

4) Plan and initiate processes to sustain achievements and continue improvements; and

5) Submit to EOHHS comprehensive written reports using the format, submission guidelines and frequency specified by EOHHS. Such reports shall include information regarding progress on Quality Improvement Goals, barriers encountered and new knowledge gained. As directed by EOHHS, the Contractor shall present this information to EOHHS at the end of the Quality Improvement Goal cycle.

e. CMS-Specified Performance Measurement and Performance Improvement Projects

The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 CFR 438.330.

f. Assessments of Care Provided to Enrollees with Special Health Care Needs

The Contractor shall assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs;

g. Assessments of care provided to Enrollees with LTSS needs.

h. HEDIS

The Contractor shall submit to EOHHS its HEDIS Interactive Data Submission System (IDDS) and member level detail data in a form and format specified by EOHHS.

2. External Quality Review (EQR) Activities

a. The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities, in accordance with 42 CFR 438.358. EQR Activities shall include, but are not limited to:

1) Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;

2) Annual validation of performance improvement projects required by

EOHHS;

3) At least once every three years, review of compliance with standards mandated by 42 CFR Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees; and

4) Annual validation of network adequacy during the preceding 12 months.

b. The Contractor shall take all steps necessary to support the EQRO in conducting EQR Activities including, but not limited to:

1) Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

a) Oversee and be accountable for compliance with all aspects of the EQR activity;

b) Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO and EOHHS staff in a timely manner;

c) Serve as the liaison to the EQRO and EOHHS and answer questions or coordinate responses to questions from the EQRO and EOHHS in a timely manner; and

d) Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR Activity and as requested by the EQRO or EOHHS.

2) Maintaining data and other documentation necessary for completion of EQR Activities specified in **Section 2.14.C.2.a** above. The Contractor shall maintain such documentation for a minimum of seven years;

3) Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or EOHHS;

4) Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;

5) Implementing actions, as directed by EOHHS, to address recommendations for quality improvement made by the EQRO, and sharing outcomes and results of such activities with the EQRO and EOHHS in subsequent years; and

6) Participating in any other activities deemed necessary by the EQRO and

approved by EOHHS.

3. QM/QI for Utilization Management Activities

The Contractor shall utilize QM/QI to ensure that it maintains a well-structured Utilization Management (UM) program that supports the application of fair, impartial and consistent UM determinations and shall address findings regarding the underutilization and overutilization of services. The QM/QI activities for the UM Program shall include:

a. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue medically necessary services;

b. At least one designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, and at least one designated Behavioral Health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, representative of the Contractor or Subcontractor, with substantial involvement in the UM program; and

c. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QM/QI processes to support its UM program. Such document may be included in the QM/QI description, or in a separate document, and shall address how the UM program fits within the QM/QI structure, including how the Contractor collects UM information and uses it for QI activities.

4. Clinical Practice Guidelines

The Contractor shall:

a. Adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field or the Contractor's approved behavioral health performance specifications and Clinical Criteria;

2) Consider the needs of Enrollees;

3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties;

4) Prior to adoption, have been reviewed by the Contractor's Medical

Director, as well as other of the Contractor's practitioners and Network Providers, as appropriate; and

5) Are reviewed and updated, as appropriate, or at least every two years:

a) Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care professionals; and

b) For guidelines that have been in effect two years or longer, the Contractor shall document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;

b. Disseminate, in a timely manner, the clinical guidelines to all new Network Providers, to all affected Providers, upon adoption and revision, and, upon request, to Enrollees and Potential Enrollees. The Contractor shall make the clinical guidelines available via the Contractor's Web site. The Contractor shall notify Providers of the availability and location of the guidelines, and shall notify Providers whenever changes are made;

c. Establish explicit processes for monitoring the consistent application of clinical guidelines across Utilization Management decisions and other coverage of services decisions as permitted under this Contract, and Enrollee education decisions; and

d. Submit to EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

5. QM/QI Workgroups

As directed by EOHHS, the Contractor shall actively participate in QM/QI workgroups that are led by EOHHS, including the BHAC, attended by representatives of EOHHS, MassHealth-contracted health plans, and other entities, as appropriate, and that are designed to support QM/QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

6. Healthcare Plan Effectiveness Data and Information Set

The Contractor shall collect annual HEDIS data and contribute to all HEDIS related processes, as directed by EOHHS, and as follows:

a. Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports;

b. Collect and submit to EOHHS, annually, full Interactive Data Submission System (IDSS) for HEDIS measures as reported to NCQA for monitoring purposes that may be publicly reported as determined by EOHHS;

c. Upon request, submit to EOHHS Contractor-stratified rates for selected HEDIS measures specified by EOHHS. Stratifications of measures may include age, race, ethnicity, language, disability status, sexual orientation, gender identity, health-related social needs, or other demographic elements as available.

d. Contribute to EOHHS's data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS;

e. If directed by EOHHS, contribute to EOHHS processes regarding the individual and aggregate performance of MassHealth-contracted managed care plans and the PCC Plan with respect to selected HEDIS measures; and

f. Contribute to EOHHS processes culminating in the publication of any technical or other reports by EOHHS related to selected HEDIS measures.

D. EOHHS-Directed Performance Incentive Program

1. EOHHS may establish a Program of Performance Incentives. In order to receive any performance incentive payment, the Contractor shall comply with all EOHHS performance incentive requirements while maintaining satisfactory performance on all other contract requirements. The EOHHS Program of Performance Incentives may reward:

   a. Improvement in Clinical Outcomes: Achievement of a certain pre-specified clinical goal;

   b. Process Improvement: compliance with certain quality improvement processes or protocols; and

   c. Participation in Quality Improvement Activities: simple participation in a designated quality improvement activity.

2. Provider Performance Incentives: The Contactor shall implement Provider Performance Incentives (or pay-for-performance), as directed by EOHHS and as appropriate, to promote compliance with guidelines and other QI initiatives, in accordance with **Section 5.1.H**. The Contractor shall:

   a. Implement Provider Performance Incentives with best efforts to collaborate with Network Providers in development and revision of the incentives;

b. Take measures to monitor the effectiveness of such Provider Performance Incentives, and to revise incentives as appropriate, with consideration of Provider feedback;

c. Collaborate with EOHHS to design and implement Performance Incentives that are consistent with or complimentary to Performance Incentives established by the PCC Plan;

d. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Provider Performance Incentives; and

e. Ensure that all Provider Performance Incentives comply with all applicable state and federal laws.

E. Enrollee Incentives

1. The Contractor may implement Enrollee Incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits, Wellness Initiatives). The Contractor shall:

a. Take measures to monitor the effectiveness of such Enrollee Incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

b. Ensure that the nominal value of Enrollee Incentives do not exceed $100; and

c. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Enrollee Incentives and assure that all such Enrollee Incentives comply with all applicable state and federal laws.

2. Provision of reasonable compensation to Enrollees for participation in the Contractor's Governing Board, Patient and Family Advisory Committee, or other Contractor efforts focused on seeking input from Enrollees shall not be considered Enrollee Incentives. The Contractor shall ensure that any such compensation complies with all applicable state and federal law. As directed by EOHHS, the Contractor shall submit to EOHHS information relating to any such reasonable compensation, in a form and format and at a frequency specified by EOHHS.

F. Behavioral Health Services Outcomes

1. The Contractor shall require Behavioral Health Providers to measure and collect clinical outcomes data, to incorporate that data in treatment planning and within the medical record, and to make clinical outcomes data available to the Contractor, upon request;

2. The Contractor's Behavioral Health Provider contracts shall require the Provider to make available Behavioral Health Clinical Assessment and outcomes data for quality management and Network Management purposes;

3. The Contractor shall use outcome measures based on behavioral health care best practices. As directed by EOHHS, the Contractor shall collaborate with Behavioral Health Providers to develop outcome measures that are specific to each Behavioral Health Service type. Such outcome measures may include:

    a. Recidivism;

    b. Adverse occurrences;

    c. Treatment drop-out;

    d. Length of time between admissions; and

    e. Treatment goals achieved.

G. External Research Projects

The Contractor may participate in external research projects that are pre-approved by EOHHS, at the discretion of the Contractor, through which the Contractor supplies Enrollee data to an external individual or entity. The Contractor shall:

1. As a covered entity (CE), follow HIPAA privacy and security rules with respect to Protected Health Information (PHI), in accordance with 45 CFR § 164.501 and **Section 5.2** of this Contract;

2. Submit to EOHHS, at the direction of and in a form and format specified by EOHHS, an application to participate in an external study and application for release of MassHealth data, as appropriate, for prior review and approval; and

3. Submit to EOHHS, the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

H. External Audit/Accreditation Results

The Contractor shall:

1. Be accredited by the National Committee on Quality Assurance (NCQA), at the health plan (i.e., Managed Care Organization) level for the entire Medicaid population;

2. Annually, inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to EOHHS, at the direction of EOHHS, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any; and

3. Authorize NCQA to provide EOHHS a copy of its most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings; and expiration date of accreditation.

I. Health Information System

The Contractor shall maintain a health information system or systems consistent with the requirements set forth in **Section 2.15.E**. and 42 CFR 438.242 and that supports all aspects of the QM/QI Program.

Section 2.15 Data Management, Information Systems Requirements, and Reporting Requirements

A. General Requirements

The Contractor shall:

1. Maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract, as described in this Section and as further directed by EOHHS;

2. Ensure a secure, HIPAA-compliant exchange of Member and Enrollee information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to and from EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS, as further directed by EOHHS;

3. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to locate all relevant information quickly and easily, as specified by EOHHS. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal;

4. Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS; and

5. Actively participate in any EOHHS data management workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS, as further directed by EOHHS;

B. Encounter Data

The Contractor shall collect, manage, and report Encounter Data as described in this Section and as further specified by EOHHS, including specifications documented in **Appendix E**, which EOHHS may update at any time. The Contractor shall:

1. Collect and maintain Encounter Data for all ACO Covered Services provided to Enrollees, including services provided through any Material Subcontractor.

2. Participate in site visits and other reviews and assessments by EOHHS for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;

3. Participate in periodic, up to quarterly, data management reviews to identify and remediate Encounter Data gaps in advance of key business process deadlines.

4. Upon request by EOHHS, assist with validation assessments by providing Enrollees' medical records and a report from specified administrative databases of the Encounters

related to those Enrollees;

5. Produce, maintain, and validate Encounter Data according to the specifications, format, and mode of transfer reasonably established by EOHHS, including, but not limited to, the data elements described in **Appendix E**, specified information about the delivering physician, and elements and level of detail determined necessary by EOHHS. As directed by EOHHS, such Encounter Data shall also include:

    a. The most current version of Encounters;

    b. 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; and

    c. information related to denied claims and 340B Drug Rebate indicators;

    d. All EPSDT screens, including behavioral health screenings; and

    e. All initial Behavioral Health Clinical Assessments

6. Provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. The Contractor shall submit Encounter Data by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix E**;

7. Submit Encounter Data that is at a minimum compliant with the standards specified in **Appendix E**, including but not limited to data quality requirements for completeness and accuracy. The Contractor shall meet data quality requirements regarding completeness, accuracy, timeliness, and consistency to ensure Encounter Data is correct, provable, and trusted.

8. Correct and resubmit rejected Encounter Data as necessary, per the standards specified in **Appendix E**. The Contractor shall submit any correction and manual override files within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix E**.

9. Report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid. At EOHHS' request, the Contractor shall submit denied claims as part of its Encounter Data submission, as further specified by EOHHS.

10. As further described in **Appendix E**, submit on a monthly basis a crosswalk between the Contractor's internal provider identification numbers and MassHealth PID/SLs in coordination with MassHealth.

11. Comply with any modifications EOHHS makes to the specifications required for submission of Encounter Data, including but not limited to requiring the Contractor to submit additional data fields to support the identification of Enrollees' affiliation with their Primary Care Provider.

12. At a time specified by EOHHS, comply with all Encounter Data submission requirements related to HIPAA and the ASCX12N 837 format. This may include submitting Encounter Data to include professional, institutional and dental claims and submitting pharmacy claims using NCPDP standards. This submission may require the Contractor to re-submit Encounter Data previously submitted to EOHHS in alternative formats. This may also require the Contractor to assess testing milestones, provide a stabilization plan, and monitor timeliness of post-production issue resolution.

13. Participate in, and be responsive to requests for information during, EOHHS' quarterly assessment of the Contractor's Encounter Data submissions. Such assessment shall include, but may not limited to, determining the Contractor's compliance with the following:

    a. Meeting the specifications in **Appendix E**

    b. Being responsive to Encounter Data related inquiries by EOHHS, including but not limited to investigations of data observations and implementation of data fixes;

    c. Avoiding critical failures or disruptions to EOHHS' data submission, processing, and downstream analytics; and

    d. Meeting the completeness, accuracy, timeliness, quality, form, format, and other standards in this **Section 2.15.B** and as further specified by EOHHS.

14. If EOHHS, or the Contractor, determines at any time, including during any of the quarterly assessments described in **Section 2.15.B.13**, that the Contractor's Encounter Data is not compliant with the specifications described in **Section 2.15.B.13**, the Contractor shall:

    a. Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate;

    b. Submit for EOHHS approval, within a time frame established by EOHHS which shall not exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a data remediation action plan and timeline for resolution to bring the accuracy and completeness to an acceptable level.

        1) Such action plan shall be reviewed and approved by EOHHS. The Contractor shall modify its proposed action plan as requested by EOHHS.

2) The Contractor may request an extension at least three business days prior to the due date of the data remediation action plan described in this **Section 2.15.B.14**, including with its request the reason for the needed extension and an action plan and timeline for when the Contractor is able to submit its proposed action plan.

c. Implement the EOHHS-approved data remediation plan within a time frame approved by EOHHS, which shall not exceed 30 days from the date that the Contractor submits the data remediation plan to EOHHS for approval; and

d. Participate in a validation study to be performed by EOHHS following the end of a twelve-month period after the implementation of the data remediation action plan to assess whether the Contractor's Encounter Data is compliant with the standards described in **Appendix E**;

15. If the Contractor fails to satisfy the data remediation plan requirements as set forth in **Section 2.15.B.14**, EOHHS shall apply a capitation payment deduction as specified in **Section 5.4.D**

C. Drug and Non-Drug Pharmacy Product Rebate Data

The Contractor shall collect, manage, and report Drug and Non-Drug Pharmacy Product Rebate Data as described in this Section and as further specified by EOHHS. The Contractor shall:

1. Collect and retain 100% of the Drug and Non-Drug Pharmacy Product Rebate Data for drugs and non-drug pharmacy products dispensed by pharmacies in accordance with **Appendix A** and 100% of the Drug and Non-Drug Pharmacy Products Rebate Data for physician-administered drugs in accordance with **Appendix E**. In addition, the Contractor shall:

a. Ensure Drug and Non-Drug Pharmacy Product Rebate Data is consistent with MassHealth eligibility data;

b. Create and maintain the file record layouts/schemas in accordance with EOHHS requirements for the purposes of capturing and submitting all drug and Non-Drug Pharmacy Product claims, whether pharmacy or physician-administered, to EOHHS and its designee. The Contractor shall satisfy any EOHHS-required timely updates to the file record layouts/schema in response to changing requirements;

c. Submit Drug Rebate and Non-Drug Pharmacy Product Rebate Data files in accordance with the EOHHS-specified schedules for those submissions;

1) The Contractor shall validate that all National Drug Codes (NDCs) submitted on physician- administered drugs for rebate match the Healthcare Common Procedure Coding System (HCPCS) being billed for, and include accurate NDC information (unit of measure and quantity);

2) The Contractor shall instruct Providers to use the indicators directed by EOHHS to identify 340B claims. The Contractor shall not rely on the use of the HRSA's 340B Medicaid Exclusion File (MEF) to identify 340B claims.

3) The Contractor shall include 340B claims with such indicators directed by EOHHS with the submission of Drug and Non-Drug Pharmacy Product Rebate Data files.

d. In the event EOHHS or its designee is unable to accept certain Drug and Non-Drug Pharmacy Product Rebate Data records due to validation errors, retrieve and promptly correct those claim records and resubmit them in accordance with current EOHHS schema and schedules;

e. Participate in workgroups, discussions, and meetings with EOHHS and its designees to support MassHealth rebate invoicing to drug manufacturers.

2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Drug and Non-Drug Pharmacy Product Rebate Data;

3. Produce Drug and Non-Drug Pharmacy Product Rebate Data according to the specifications, format, and mode of transfer reasonably developed by EOHHS or its designee;

4. Provide Drug and Non-Drug Pharmacy Product Rebate Data to EOHHS monthly or within time frames specified by EOHHS, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations, and guidance;

5. Submit Drug and Non-Drug Pharmacy Product Rebate Data that is 100% on time and 99% complete. To meet the completeness standard, all critical fields in the data shall contain valid values. The Contractor shall correct and resubmit errored claims as necessary;

6. Report as voided or reversed any claims in the Drug and Non-Drug Pharmacy Product Rebate Data submission that the Contractor includes in a file and then later determines shall not have been included;

7. Ensure that the Drug Rebate and Non-Drug Pharmacy Product rebate contractual requirements are transferred completely and without interruption to the published MassHealth Drug Rebate and Non-Drug Pharmacy Product rebate file upload schedule whenever there is a change in the Drug Rebate operations and/or technical support staff; and

8. If EOHHS or the Contractor determines at any time that the Contractor's Drug Rebate and Non-Drug Pharmacy Product Data will not be or is not 100% on time and 99% complete:

a. Notify EOHHS, five days prior to the Drug Rebate and Non-Drug Pharmacy Product Data scheduled submission date, that the Drug Rebate and Non-Drug Pharmacy Product Data will not be delivered on time or is not complete and provide an action plan and timeline for resolution;

b. Submit a corrective action plan to EOHHS, for approval, within a timeframe not to exceed 30 days, from the day the Contractor identifies or is notified that it is not in compliance with the Drug Rebate and Non-Drug Pharmacy Product Data requirements, to implement improvements or enhancements to bring the timeliness and completeness to an acceptable level;

c. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

d. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Drug Rebate and Non-Drug Pharmacy Product Data is 100% on time and 99% complete. The Contractor may be financially liable for such validation study.

D. Medical Records

The Contractor shall:

1. At a minimum, comply with, and require Network Providers to comply with, all statutory and regulatory requirements applicable to Enrollee medical records, including, but not limited to those contained in 130 CMR 433.409 and 450.205, and any amendments thereto. In addition, all Enrollee medical records, whether paper or electronic shall, at a minimum:

   a. Be maintained in a manner that is current, detailed, and organized and that permits effective patient care, utilization review and quality review;

   b. Include sufficient information to identify the Enrollee, date of encounter and pertinent information which documents the Enrollee's diagnosis;

   c. Describe the appropriateness of the treatment/services, the course and results of the treatment/services and treatment outcomes;

   d. Be consistent with current and nationally accepted professional standards for providing the treatment/services, as well as systems for accurately documenting the following:

      1) Enrollee information including, among other things, primary language spoken;

2) Clinical information;

3) Clinical assessments;

4) Treatment plans;

5) Treatment/services provided;

6) Contacts with the Enrollee's family, guardians, or significant others;

7) Treatment goals and outcomes;

8) All contacts with state agencies, as applicable; and

9) Pharmacy records;

e. Be consistent with commonly accepted standards for medical record documentation, as follows:

1) Each page in the record contains the patient's name or ID number;

2) Personal biographical data include the address, home telephone, mobile telephone, and work telephone numbers, name of employer, marital status, primary language spoken, and any disabilities, such as visually impaired, hearing impaired, uses a wheelchair;

3) All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials;

4) All entries are dated;

5) The record is legible to someone other than the writer;

6) Significant illnesses and medical conditions are indicated on the problem list;

7) Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record;

8) Past medical history is easily identified and includes serious accidents, operations and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations and childhood illnesses;

9) For children, adolescents and adults, there is appropriate notation

concerning the use of cigarettes, alcohol and substances;

10) The history and physical examination identify appropriate subjective and objective information pertinent to the patient's presenting complaints;

11) Laboratory and other studies are ordered, as appropriate;

12) Working diagnoses are consistent with findings;

13) Treatment plans are consistent with diagnoses;

14) Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months, or as needed;

15) Unresolved problems from previous office visits are addressed in subsequent visits;

16) For children, adolescents and adults, there is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals;

17) If a consultation is requested, there is a note from the specialist in the record;

18) Consultation, laboratory and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans;

19) There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure;

20) An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults); and

21) There is evidence that preventive screening and services are offered in accordance with the EPSDT Periodicity Schedule or, for individuals over age 21, the Provider's own practice guidelines, including the administration of behavioral health screenings in accordance with **Section 2.8.C.1**.

f. For records pertaining to inpatient hospital services, include the following

information as set forth in 42 CFR 456.111:

1) Identification of the Enrollee;

2) The name of the Enrollee's physician;

3) Date of admission, and dates of application for and authorization of MassHealth benefits if application is made after admission;

4) The plan of care required under 42 CFR 456, et seq.;

5) Initial and subsequent continued stay review dates described under 42 CFR 456.128 and 456.133;

6) Date of operating room reservation, if possible;

7) Justification of emergency admission, if applicable;

8) Reason and plan for continued stay if the attending physician believes continued stay is necessary; and

9) Other supporting material that the Contractor's Utilization Management staff, such as the staff described in **Section 2.7.D.1** of this Contract, believes appropriate to be included in the record.

2. For records pertaining to inpatient services in mental hospitals, include the following information as set forth in 42 CFR 456.211:

1) Identification of the Enrollee;

2) The name of the Enrollee's physician;

3) Date of admission, and dates of application for and authorization of MassHealth benefits if application is made after admission;

4) The plan of care required under 42 CFR 456.172 and 42 CFR 456.180;

5) Initial and subsequent continued stay review dates described under 42 CFR 456.233 and 456.234;

6) Reason and plan for continued stay if the attending physician believes continued stay is necessary; and

7) Other supporting material that the Contractor's Utilization Management staff, such as the staff described in **Section 2.7.D.1** of this Contract, believes appropriate to be included in the record.

3. Provide a copy of medical records pertaining to Enrollees, at EOHHS's request, for the

purpose of monitoring the quality of care provided by the Contractor in accordance with federal law (e.g., 42 USC 1396a(a)(30)), or for the purpose of conducting performance evaluation activities of the Contractor as described in **Section 2.14**, including, but not limited to, EOHHS's annual External Quality Review and outcomes measurement studies performed by EOHHS. Medical record audits conducted by the Contractor at the request of EOHHS may be subject to validation performed directly by EOHHS or its agent.

The Contractor shall provide any such medical or audit record(s) within 10 days of EOHHS's request, provided however, that EOHHS may grant the Contractor up to 30 days from the date of EOHHS's initial request to produce such record(s) if the Contractor specifically requests such an extension and where EOHHS reasonably determines that the need for such record(s) is not urgent and the Contractor is making best efforts to produce such record(s) in a timely fashion.

4. In the event of termination or expiration of the Contract, or in the event of Enrollee disenrollment, transfer all medical records and other relevant information in the Contractor's possession, in a format to be specified by EOHHS, to EOHHS, another Contractor, or other party as determined by EOHHS.

5. Ensure its HIS collects, analyzes, integrates, and reports data, including, but not limited to information regarding:

    a. Utilization (including Non-ACO Covered Services);

    b. Inquiries, Grievances, Internal Appeals, and BOH Appeals;

    c. Disenrollments for reasons other than for loss of MassHealth eligibility;

    d. Provider information in order to comply with **Section 2.11.H**;

    e. Services furnished to Enrollees through an Encounter Data system, as specified in **Section 2.15.B**;

6. Enrollee characteristics, including but not limited to, race, ethnicity, spoken language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheel chair use, sexual orientation and gender identity, and characteristics gathered through such Plan contact with Enrollees, e.g., Care Needs Screenings administered upon enrollment, Care Management, or other reliable means;

7. 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;

8. 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;

9. Make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(4);

10. Design Requirements

a. Comply with EOHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

b. Ensure the Contractor's Systems interface with EOHHS's Legacy MMIS system, EOHHS's MMIS system, the EOHHS Virtual Gateway, and other EOHHS IT architecture as further specified by EOHHS.

c. Have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files, as specified in **Appendix J** of this Contract.

d. Conform to HIPAA compliant standards for data management and information exchange;

e. Demonstrate controls to maintain information integrity;

f. Maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS; and

11. As set forth in 42 CFR 438.242(b)(1), comply with Section 6504(a) of the Affordable Care Act;

E. Health Information Technology and Health Information Exchange

1. The Contractor shall, as further specified by EOHHS, establish and implement policies and procedures to:

a. Enhance interoperability of its health information technology through health information exchange technologies;

b. Increase utilization of health information exchange services operated or promoted by the Mass HIway, including but not limited to direct messaging,

Statewide event notification service (ENS) Framework, and Query and Retrieve functionality;

c. Upon notification by EOHHS that additional Mass HIway services are developed, operated, or promoted, establish and implement policies and procedures to increase connectivity to such services and work with its Network PCPs to increase their connectivity;

d. Increase its ability to make electronic Health Related Social Needs (HRSN) referrals (e.g., secure email, SFTP, platform integrated into EHRs) and to receive updates from Social Services Organizations providing HRSN supports to Enrollees;

2. The Contractor shall provide EOHHS with such policies and procedures described above upon EOHHS request;

3. The Contractor shall plan to develop, establish, or enhance existing Electronic Clinical Data Systems (ECDS), with the capability to collect data to calculate Electronic Clinical Quality Measures (eCQMs) or Digital Quality Measures (dQMs) as directed by EOHHS. The Contractor shall submit data or results for eCQM, dQM or other electronic measures to EOHHS as directed by EOHHS;

4. The Contractor shall ensure that its Network PCPs are be able to access or receive event notifications from an EOHHS-Certified ENS Vendor participating in the Statewide ENS Framework. The Contractor shall also establish and implement policies and procedures for its Network PCPs to integrate such event notifications into appropriate Care Management or population health management workflows;

5. The Contractor shall ensure that its Network PCPs enable and utilize Query and Retrieve functionality that is natively available in the Network PCPs' EHRs, as further specified by EOHHS;

6. The Contractor shall have at least 75% of its Providers who are EHR Eligible Clinicians adopt and integrate interoperable Electronic Health Records (EHR) certified by the Office of the National Coordinator (ONC) using ONC's 2015 certification edition, along with subsequent edits to the 2015 certification edition pursuant to the 21st Century Cures Act;

7. The Contractor shall make available or ensure availability to relevant Providers, staff, and subcontractors, including but not limited to Community Partners, an up-to-date electronic community resource database (CRD) that can be used to identify providers and supports that can address identified HRSNs. The Contractor shall provide necessary education and training to relevant Providers, staff, and sub-Contractors (e.g., Community Partners) about how to use the CRD;

8. The Contractor shall maintain a health information system (HIS) or Information Systems (together, the Contractor's Systems) as follows:

a. Such Systems shall enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract. The Contractor's Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following EOHHS standards as they may be updated from time to time:

1) The EOHHS Unified Process Methodology User Guide;

2) The User Experience and Style Guide Version 2.0;

3) Information Technology Architecture Version 2.0; and

4) Enterprise Web Accessibility Standards 2.0.

F. Claims Processing Requirements

1. The Contractor shall operate and maintain an industry standard HIPAA-compliant, on-line Claims processing system that includes but is not limited to the following characteristics:

a. Supports HIPAA standard Inbound and Outbound Transactions, as defined by EOHHS:

1) Health Care Claim Status Request and Response (276/277)

2) Health Care Services Review – Request and Response (278)

3) Health Care Claim Payment/Advice (835)

4) Health Care Claim/Professional (837P)

5) Health Care Claim/Institutional (837I)

6) Health Care Eligibility Benefit Inquiry and Response (270/271)

7) Functional Acknowledgement for Health Care Insurance (997)

8) Implementation Acknowledgement for Health Care Insurance (999)

b. Complies with all future updates to the HIPAA transactions and standards within the required timeframes;

c. Has flexibility to receive Provider claims submitted in various HIPAA compliant formats. The Contractor shall collaborate with Providers to allow Providers to submit Claims utilizing various industry standard procedures;

d. Adjudicates Claims submitted in accordance with the timeframes specified in

Section 2.8.D.1;

2. In addition, the Contractor shall:

    a. Implement timely filing initiatives to ensure that Claims are submitted within the allotted time restrictions set by the Contractor;

    b. Implement waiver parameters for Providers that do not meet allotted time restrictions including but not limited to a waiver at the request of EOHHS; and

    c. Implement and maintain policies and procedures related to the financial, eligibility, and clinical editing of Claims. These policies and procedures shall include an edit and audit system that allows for editing for reasons such as, ineligibility of Enrollees, providers and services; duplicate services; and rules or limitations of services. As further specified by EOHHS, the Contractor shall report these edits to EOHHS.

3. Claims Review

    The Contractor shall:

    a. Maintain written, EOHHS-approved Claims resolution protocols. The Contractor shall submit any proposed changes to such protocols to EOHHS for prior review and approval and implement such changes upon the date specified by EOHHS;

    b. Review Claims resolutions protocols no less frequently than annually and, as appropriate, recommend modifications to the protocols to EOHHS to increase the efficiency or quality for the Claims resolution process;

    c. Review suspended Claims for reasons why Claims were suspended, including reasons specified by EOHHS;

    d. Review all Claims that suspend for being untimely in accordance with EOHHS-approved protocols. The Contractor shall waive the timeliness deadline for those Claims meeting the EOHHS-approved criteria as described in **Section 2.15.A.2** and as further described by EOHHS.

    e. Implement appropriate quality control processes to ensure that Claim review requirements are met within EOHHS-defined parameters including but not limited to maintaining an electronic record or log of the quality review process.

4. Recoveries and Erroneous Payments

    The Contractor shall notify EOHHS of recoveries and erroneous payments as described in **Section 2.3.D**.

5. The Contractor shall at a minimum have systems in place to monitor and audit claims.

G. Reports, Notifications, and Related Systems

1. General

a. The Contractor shall provide and require its Material Subcontractors and other subcontractors to provide, in accordance with the timelines, definitions, formats and instructions contained herein or as further specified by EOHHS:

1) All information required under this Contract, including but not limited to, the requirements of **Appendix A** or other information related to the performance of its or their responsibilities hereunder or under the subcontracts as reasonably requested by EOHHS;

2) Any information in its or their possession sufficient to permit EOHHS to comply with 42 CFR Part 438;

3) Any data from their clinical systems, authorization systems, claims systems, medical record reviews, Network Management visits, and Enrollee and family input;

4) Time sensitive data to EOHHS in accordance with EOHHS timelines; and

5) High quality, accurate data in the format and in the manner of delivery specified by EOHHS;

b. The Contractor shall participate in work groups led by EOHHS to develop and comply with reporting specifications and to adopt the reporting models formulated by these work groups and approved by EOHHS, pursuant to the timeline established by EOHHS; and

c. Upon request, the Contractor shall provide EOHHS with the original data sets used by the Contractor in the development of any required reporting or ad-hoc reporting in accordance with the time frames and formats established by EOHHS;

2. Contract-Related Reports

The Contractor shall meet all Contract-related report requirements, which include, but are not limited to, reports related to Contract performance, management and strategy as set forth in **Appendix A**.

a. The Contractor shall submit **Appendix A** reports in accordance with the timeframes and other requirements specified in **Appendix A**, and consistent with any form and format requirements specified by EOHHS. For any report that indicates the Contractor is not meeting the targets set by EOHHS, the Contractor shall provide immediate notice explaining the corrective actions it is taking to improve performance. Such notice shall include root cause analysis of the

problem the data indicates, the steps the Contractor has taken to improve performance, and the results of the steps taken to date. The Contractor may also include an executive summary to highlight key areas of high performance and improvement.

b. Failure to meet the reporting requirements in **Appendix A** shall be considered a breach of Contract.

3. Internal Management Reports

The Contractor shall submit to EOHHS, upon request, any internal reports that the Contractor uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/ loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance.

4. Additional Reports

a. In addition to the reports specifically required in **Appendix A**, the Contractor shall participate with EOHHS in the development of additional reports based on specific topics identified jointly by EOHHS and the Contractor as a result of ongoing analysis and review of data, and/or administrative and clinical processes. The Contractor shall participate in meetings led by EOHHS to develop analytical approaches and specifications for such reports. The Contractor shall produce data and written analyses of each topic in a time frame established by EOHHS but, at minimum, by the end of each Contract Year.

b. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with the provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance. Further, the Contractor shall correct any errors in such reports in accordance with EOHHS guidelines.

c. Pursuant to 42 CFR 438.3(g), the Contractor shall comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS.

d. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with program report requirements set forth in 42 CFR 438.66(e).

5. Other Ad Hoc Reports

The Contractor shall provide EOHHS with additional ad hoc or periodic reports related to this Contract at EOHHS's request in the time frame and format specified by EOHHS.

6. Healthcare Plan Effectiveness Data and Information Set (HEDIS)

In accordance with **Section 2.14**, and as further specified by EOHHS, the Contractor shall submit HEDIS data annually, six months after the end of the HEDIS reporting period in accordance with the format, method and time frames specified by EOHHS. .

7.

8. Quality Measure reporting

As further specified by EOHHS, in accordance with **Section 2.14**, and in a form and format specified by EOHHS, the Contractor shall provide EOHHS with data on the Clinical Quality Measures set forth in **Appendix Q** for each Quality Sample as follows:

a. For each Clinical Quality Measure, the Contractor shall provide EOHHS with complete and accurate medical record data as requested by EOHHS for each Enrollee in the Quality Sample;

b. The Contractor shall provide all requested clinical data in a form and format determined by EOHHS, within the timeframes specified by EOHHS. Additionally, the Contractor shall provide such data in aggregate form, if so requested by EOHHS; and

c. The Contractor shall provide EOHHS with any additional data or information as requested by EOHHS to audit or validate the quality data the Contactor provides in accordance with this Section;

9. Documentation

Upon EOHHS' request, the Contractor shall submit any and all documentation and materials pertaining to its performance under this Contract in a form and format designated by EOHHS. Such documentation shall include, but shall not be limited to the Contractor's:

a. List of PCPs, and documentation demonstrating Contractor's compliance with the requirements of **Section 2.8.C.1**, including but not limited to model and executed contracts between Contractor and PCPs;

b. Documentation demonstrating Contractor's compliance with the requirements of **Section 2.3.A.2**, including but not limited to model and executed contracts between Contractor and Contractor's ACO Partner;

c. Materials provided to Enrollees as set forth in this Contract;

d. Marketing plan and Marketing materials;

e. Grievance policies and procedures; and

f. Any other documentation and materials requested by EOHHS.

10. Additional Clinical Data

a. Upon request of EOHHS, the Contractor shall participate in the development of specifications for a data set on clinical data in the Contractor's Systems that include member identifier, and data on participation in the Children's Behavioral Health Initiative, Care Management programs and special populations; and

b. At the discretion of EOHHS, a data set developed on member enrollment in special programs and populations shall be produced and submitted to EOHHS in the frequency and format to be determined by EOHHS.

11. System Exchange of Encounter Data

a. The Contractor's Systems shall generate and transmit Encounter Data files according to the specifications outlined in **Appendix E** of this Contract, as updated from time-to-time:

b. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in **Section 2.15.B**; and

c. The Contractor shall participate in any Workgroup activities as specified in **Section 2.15.A**.

12. System Access Management and Information Accessibility Requirements

a. The Contractor shall make all Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and Systems.

13. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

14. System Availability and Performance Requirements

a. The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers 24 hours a day, seven days a week.

b. The Contractor shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to EOHHS upon request. In the event of System failure or unavailability, the Contractor shall notify EOHHS upon discovery and

implement the COOP immediately.

c. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

15. Virtual Gateway

If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, the Contractor shall:

a. Submit all specified information including, but not limited to, invoices, Contract or other information to EOHHS through these web-based applications;

b. Comply with all applicable EOHHS policies and procedures related to such services;

c. Use all business services through the Virtual Gateway as required by EOHHS;

d. Take necessary steps to ensure that it, and its subcontractors or affiliates, has access to and utilize all required web-based services; and

e. Execute and submit all required agreements, including subcontracts, Memoranda of Agreements, confidentiality and/or end user agreements in connection with obtaining necessary end user accounts for any Virtual Gateway business service.

16. Notification of Hospital Utilization

The Contractor shall indicate, as set forth in **Appendix A**, at a frequency specified by EOHHS, that it has notified each Massachusetts acute hospital of the number of inpatient days of service provided by each hospital to Enrollees who receive inpatient hospital services under this Contract pursuant to G M.G.L. c. 118E, § 13F.

H. Certification Requirements

In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive Officer or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit to EOHHS certification checklists in the form and format provided in **Appendix A**, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of their knowledge, information and belief, after reasonable inquiry, under the penalty of perjury:

1. Data on which payments to the Contractor are based;

2. All enrollment information, Encounter Data, and measurement data;

3. Data related to medical loss ratio requirements in aggregate for the Contractor's Enrollee population;

4. Data or information related to protection against the risk of insolvency;

5. Documentation related to requirements around Availability and Accessibility of services, including adequacy of the Contractor's Provider Network;

6. Information on ownership and control, such as that pursuant to **Section 5.1.O**;

7. Reports related to overpayments; and

8. Data and other information required by EOHHS, including but not limited to, reports and data described in this Contract.

I. Data and Reporting to PCPs

1. The Contractor shall provide to its Network PCPs a set of data supports and reports to allow the PCP to meaningful understand their performance on cost, quality measures, member experience, utilization management as well as engage in Care Management and population health management of their Enrollees, provided that the PCP has appropriate HIPAA-compliant information systems.

    a. Data supports include but are not limited to member-level raw claims files, Enrollee enrollment span files, and Enrollee rosters, actionable Enrollee lists, member lists flagging high or rising risk Enrollees or Enrollees flagged for Care Management or Community Partner (CP) Program;

    b. Reports include but are not limited to the following aggregate reports:

        1) Financial reports tracking most recent savings and losses projections, member cost trends, costs for specific service lines or categories of service, costs for different populations of Enrollees including those with higher incidence of social determinants of health or with a specific condition, and comparisons against other PCPs;

        2) Utilization reports tracking utilization rates for different service lines or categories of service, utilization rates for different populations of Enrollees including those with higher incidence of social determinants of health or with specific conditions, and comparisons against other PCPs;

        3) Quality Measure reports tracking more recent quality measure rates and comparison against other PCPs;

        4) Raw medical and pharmacy claims, and Enrollee roster and enrollment files that the Contractor supplied to EOHHS.

    c. The Contractor and its Network PCPs shall have documented agreement on the types, frequencies, and timeliness of the set of data supports and reports provided by the Contractor to the Participating PCPs. This agreement shall additionally include an agreed upon cadence for the Contractor and the PCPs,

including their practice site leaders, to engage on the output of reports to identify and jointly agree upon areas to improve Enrollee care and PCP's performance on financial, quality, and utilization goals.

Section 2.16 Financial Stability Requirements

The Contractor shall remain fiscally sound as demonstrated by the following:

A. DOI Licensure

The Contractor shall be licensed as a Health Maintenance Organization by the Massachusetts Division of Insurance (DOI), pursuant to 211 CMR 43.

B. Cash Flow

The Contractor shall maintain sufficient cash flow and liquidity to meet obligations as they become due. The Contractor shall submit to EOHHS upon request a cash flow statement to demonstrate compliance with this requirement and a statement of its projected cash flow for a period specified by EOHHS.

C. Net Worth

The Contractor shall comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G § 25 (a) and 211 CMR 43:07(1) and continue to maintain an adjusted net worth in accordance with M.G.L. c 176G § 25(b) and 211 CMR 43:07(2).

D. Cash Reserves

Throughout the term of this Contract, the Contractor shall maintain a minimum cash reserve of $1,000,000 to be held in a restricted reserve entitled "Reserve for MassHealth Managed Care Obligations." Funds from this restricted cash reserve may be dispersed only with prior written approval from EOHHS during the term of this Contract.

E. Working Capital Requirements

The Contractor shall demonstrate and maintain working capital as specified below. For the purposes of this Contract, working capital is defined as current assets minus current liabilities. Throughout the term of this Contract, the Contractor shall maintain a positive working capital balance, subject to the following conditions:

1. If, at any time, the Contractor's working capital decreases to less than 75% of the amount reported on the prior year's audited financial statements, the Contractor shall notify EOHHS within two business days and submit, for approval by EOHHS, a written plan to reestablish a positive working capital balance at least equal to the amount reported on the prior year's audited financial statements.

2. EOHHS may take any action it deems appropriate, including termination of the Contract, if the Contractor:

a. Does not maintain a positive working-capital balance; or

b. Violates a corrective plan approved by EOHHS.

F. Insolvency Protection

Throughout the term of this Contract, the Contractor shall remain financially stable and maintain adequate protection against insolvency, as determined by EOHHS. To meet this general requirement, the Contractor, at a minimum, shall comply with, and demonstrate such compliance to the satisfaction of EOHHS, the solvency standards imposed on HMOs by the Massachusetts Division of Insurance (DOI). A DOI-licensed Contractor shall submit copies of its DOI financial reports to EOHHS on a quarterly basis. The Contractor shall also submit reports set forth in **Appendix A**.

G. Medical Loss Ratio (MLR) Requirements

1. Annually, and upon any retroactive change to the Base Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio (MLR) in accordance with 42 CFR 438.8. The Contractor shall perform such MLR calculation in aggregate for Contractor's Enrollee population and individually for each Rating Category. Within 212 days following the end of the Contract Year, the Contractor shall report such MLR calculations to EOHHS in a form and format specified by EOHHS and as set forth in **Appendix A**. Such report shall include at least the following, pursuant to 42 CFR 438.8(k):

   a. Total incurred claims

   b. Expenditures on quality improving activities;

   c. Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5),(7),(8), and (b);

   d. Non-claims costs;

   e. Premium revenue;

   f. Taxes, licensing, and regulatory fees;

   g. Methodology(ies) for allocation of expenses;

   h. Any credibility adjustment applied;

   i. Any remittance owed to the State, if applicable;

   j. The calculated MLR;

   k. A comparison of the information reported in this Section with the audited financial report required under this **Section 2.16**;

l. A description of the aggregation method used in calculating MLR;

m. The number of member months;

n. An attestation that the calculation of the MLR is accurate and in accordance with 42 CFR 438.8; and

o. Any other information required by EOHHS.

2. As further specified by EOHHS, the Contractor shall calculate its MLR in accordance with 42 CFR 438.8, as follows:

a. The numerator of the Contractor's MLR for each year is the sum of the Contractor's incurred claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

b. The denominator of the Contractor's MLR for each year is the adjusted premium revenue as set forth in 42 CFR 438.8(f). For purposes of this section, the Contractor's adjusted premium revenue shall be the Contractor's premium revenue as defined in 42 CFR 438.8(f)(2) minus the Contractor's federal, state, and local taxes and licensing and regulatory fees as defined in 42 CFR 438.8(f)(3).

c. As further directed by EOHHS, the Contractor shall maintain a minimum MLR of 85 percent in aggregate for the Contractor's Enrollee population. If the Contractor does not maintain such minimum, the Contractor shall, pursuant to 42 CFR 438.8(j), remit an amount equal to the difference between actual medical expenditures and the amount of medical expenditures that would have resulted in a MLR of 85%.

H. Auditing and Other Financial Requirements

The Contractor shall:

1. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits shall comply with the following requirements and shall be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards:

a. No later than 120 days after the Contractor's fiscal year end, the Contractor shall submit to EOHHS the most recent year-end audited financial statements (balance sheet, statement of revenues and expenses, source and use of funds statement and statement of cash flows that include appropriate footnotes) both:

1) Specific to this Contract; and

2) If directed by EOHHS, statements for the overall organization or consolidated statements that include other lines of business or other Medicaid products.

b. The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS a Service Organization Controls report (SOC1 report) from its independent auditor on the effectiveness of the internal controls over operations of the Contractor, specific to this Contract in accordance with statements and standards for attestation engagements as promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report.

c. The Contractor shall submit, on an annual basis after each annual audit, the final audit report specific to this Contract, together with all supporting documentation, a representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed;

2. Utilize a methodology to estimate incurred but not reported (IBNR) claims adjustments for each Rating Category and annually provide to EOHHS a written description of the methodology utilized in the preparation of the Contractor's audited financial statements to estimate IBNR claims adjustments for each Rating Category. The Contractor shall provide EOHHS with the lag triangles and completion factors used in the development of the quarterly financial reports in accordance with reporting timelines in **Appendix A**. The Contractor shall submit its proposed IBNR methodology to EOHHS for review and approval and, as directed by EOHHS, shall modify its IBNR methodology in whole or in part;

3. Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify the Contractor's Governing Board of the potential for insolvency;

4. Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract;

5. Advise EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new Material Subcontracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract; and

6. Not invest funds in, or loan funds to, any organization in which a director or principal officer of the Contractor has a financial interest.

I. Provider Risk Arrangements

To the extent permitted by law, the Contractor may enter into arrangements with Providers that place Providers at risk subject to the following limitations:

1. No incentive arrangement may include specific payments as an inducement to withhold, limit, or reduce services to Enrollees.

2. The Contractor shall remain responsible for assuring that it complies with all of its obligations under the Contract including, but not limited to, access standards, providing all Medically Necessary ACO Covered Services and quality. The Contractor shall monitor Providers who are at risk to assure that all such requirements are met and shall terminate or modify such arrangements if necessary.

3. The Contractor shall disclose these arrangements including all contracts, appendices and other documents describing these arrangements, to EOHHS as follows:

   a. As a part of Readiness Review;

   b. As requested by EOHHS; or

   c. If there are any changes in its risk arrangements with any members of its Provider Network, including, but not limited to, primary care, specialists, hospitals, nursing facilities, other long-term care providers, behavioral health providers, and ancillary services.

J. Right to Audit and Inspect Books

The Contractor shall provide EOHHS, the Secretary of the U.S. Department of Health and Human Services, and their designees its books and records for audit and inspection of:

1. The Contractor's capacity to bear the risk of potential financial losses;

2. Services performed or the determination of amounts payable under the Contract;

3. Rates and payments made to Providers for each service provided to Enrollees; and

4. Financial data and Encounter Data, and related information, including but not limited to such data and information needed for EOHHS to conduct audits for any Contract Year in accordance with 42 CFR 438.602(e).

K. Other Information

The Contractor shall provide EOHHS with any other information that CMS or EOHHS deems necessary to adequately monitor and evaluate the financial strength of the Contractor or that must be provided to CMS or EOHHS by law. Such information shall include, but not be limited to, the revenue, expenses and utilization reports set forth in **Appendix A**; the financial ratios set

forth in **Appendix A**; and the outstanding litigation report set forth in **Appendix A**.

L. Reporting

The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 2.16** and **Appendix A**, in accordance with specified timetables, definitions, formats, assumptions, and certifications, as well as any ad hoc financial reports required by EOHHS.

Section 2.17 Performance Evaluation

The Contractor shall engage in performance evaluation activities as further specified in this Contract and by EOHHS. Such activities shall include, but may not be limited to Quality responsibilities set forth in **Section 2.14**, External Quality Review activities, and any other activities specified by EOHHS.

Section 2.18 Operational Audits

A. The Contractor or its Material Subcontractor shall cooperate and facilitate EOHHS's conduct of periodic on-site visits as described under **Section 5.5** of this Contract. At the time of such visits, the Contractor or Material Subcontractor shall assist EOHHS or its designee in activities pertaining to an assessment of all facets of the Plan's operations, including, but not limited to financial, administrative, clinical, pharmacy and claims processing functions and the verification of the accuracy of all data submissions to EOHHS as described herein.

B. The Contractor or Material Subcontractor shall respond to requests for information associated with such on-site visits in a timely manner, and shall make senior managers available for on-site reviews.

Section 2.19 Additional Enrollee Groups

A. Consistent with **Section 3.6**, EOHHS may require the Contractor to accept additional Enrollees into the Contractor's Plan including, but not limited to, Enrollees with Medicare or other third party health insurance or new expansion populations.

B. The Contractor shall cooperate with EOHHS to develop an implementation strategy for providing services to any new Enrollee group.

Section 2.20 Benefit Coordination

A. General Requirements

The Contractor shall:

1. Designate a TPL Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract.

2. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

3. Perform Benefit Coordination in accordance with this **Section 2.20**. The Contractor shall

work with EOHHS via interface transactions with the MMIS system using HIPAA standard formats to submit information with regard to TPL investigations and recoveries.

B. Third Party Health Insurance Information

1. The Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance and (2) identify other health insurance that may be obtained by an Enrollee, in accordance with **Appendix H**, using, at a minimum, the following sources:

   a. The HIPAA 834 Outbound Enrollment File (for more information on this interface with MMIS and all interfaces, see **Section 2.15.F.1**);

   b. Claims Activity;

   c. Point of Service Investigation (Customer Service, Member Services and Utilization Management); and

   d. Any TPL information self-reported by an Enrollee.

2. At a minimum, such procedures shall include:

   e. Performing a data match against the Contractor's subscriber/member list for any other product line it offers and providing this information to EOHHS or its designee in accordance with **Appendix H**; and

   f. Reviewing claims for indications that other insurance may be active (e.g., explanation of benefit attachments or third party payment).

C. Third Party Health Insurance Cost-Avoidance, Pay and Recover Later and Recovery

1. Once an Enrollee is identified as having other health insurance, the Contractor shall cost avoid claims for which another insurer may be liable, except in the case of prenatal and EPSDT services per 42 USC 1396(a)(25)(E) and 42 CFR 433.139.

2. If the Contractor also offers commercial policies or a Qualified Health Plan offered through the Exchange, the Contractor shall perform a match within their own commercial plan or a Qualified Health Plan offered through the Exchange. If an Enrollee is found to also be enrolled in the Contractor's commercial plan or a Qualified Health Plan offered through the Exchange, the Enrollee's information shall be sent to EOHHS or a designee assigned by EOHHS. EOHHS shall verify the Enrollee's enrollment and eligibility status and if EOHHS confirms that the Contractor was correct, disenroll the Enrollee retroactive to the effective date of the other insurance.

3. EOHHS shall provide the Contractor with all third party health insurance information on Enrollees where it has verified that third party health insurance exists, in accordance with **Section 3.2.**

4. The Contractor shall perform the following activities to cost-avoid, pay and recover

later, or recover claims when other health insurance coverage is available:

a. Cost-Avoidance

The Contractor shall:

1) Pend claims that are being investigated for possible third party health insurance coverage in accordance with EOHHS's guidelines as described in **Appendix H**;

2) Deny claims submitted by a Provider when the claim indicates the presence of other health insurance;

3) Instruct Providers to use the TPL Indicator Form to notify EOHHS of the potential existence of other health insurance coverage and to include a copy of the Enrollee's health insurance card with the TPL Indicator Form if possible; and

4) Distribute TPL Indicator Forms at the Contractor's Provider orientations.

b. Pay and Recover Later

The Contractor shall take all actions necessary to comply with the requirements of 42 USC 1396a(a)(25)(E) and 42 CFR 433.139.

c. Recovery

The Contractor shall:

1) Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;

2) Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable in accordance with EOHHS's guidelines as described in **Appendix H**; and

3) Develop procedures and train staff to ensure that Enrollees who have comprehensive third party health insurance are identified and reported to EOHHS.

5. Reporting

The Contractor shall report to EOHHS the following, in accordance with the requirements set forth in **Appendix A**:

a. Other Insurance – the number of referrals sent by the Contractor on the Inbound Demographic Change File, and the number of Enrollees identified as

having TPL on the monthly HIPAA 834 Inbound Enrollment file;

b. Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 USC 1396a(a)(25)(E) and 42 CFR 433.139;

c. Cost avoidance – the number and dollar amount of claims that were denied by the Contractor due to the existence of other health insurance coverage on a semi-annual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and

d. Recovery – Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan, on a semi-annual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or Provider.

D. Accident and Trauma Identification and Recovery

1. Identification

a. Claims Editing and Reporting

The Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other third party liability cases:

1) Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;

2) Provider Notification – Claims where Providers have noted accident involvement; and

3) Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident. Questionnaires will be based on a predetermined diagnosis code range.

b. Medical Management

The Contractor shall identify any requested medical services related to motor vehicle accidents, or work related injuries, and refer these claims to the recoveries specialist for further investigation.

2. Reporting

The Contractor will provide EOHHS with cost avoidance and recovery information on accidents and trauma cases as specified in **Appendix A**.

3. Cost Avoidance and Recovery

The Contractor shall recover or cost-avoid claims where an Enrollee has been involved in an accident or lawsuit in accordance with **Appendix H**.

Section 2.21 Health Equity

A. Health Equity Committee

1. At all times during the Contract Term, the Contractor or the ACO Partner shall have, or the agreement between the Contractor and ACO Partner shall establish and maintain, a Health Equity Committee (HEC) designated by, and accountable to, the Governing Board. Such Health Equity Committee may be an existing Health Equity committee, so long as the committee meets the criteria of this section.

2. The composition of the Health Equity Committee shall, to the extent possible, include individuals that represent the diversity of the MassHealth population. The HEC shall have representation from various stakeholders of the Contractor, including but not limited to:

    a. Contractor representatives;

    b. ACO Partner representatives;

    c. Representatives from Network PCPs that are high performers in Health Equity as determined by the Contractor, including FQHCs;

    d. At least two MassHealth ACO Enrollees or family members of MassHealth ACO Enrollees;

    e. Providers; and

    f. Frontline staff (e.g., Community Health Workers).

3. Responsibilities of the Health Equity Committee include but are not limited to:

    a. Developing and steering implementation of the Contractor's Health Equity strategy;

    b. Monitoring progress towards addressing inequities;

    c. Developing Health Equity reporting in accordance with **Appendix A**; and

    d. Sharing all relevant information with the Contractor's PFAC.

B. Population and Community Needs Assessment

1. The Contractor shall conduct a population and community needs assessment that provides a description of the Contractor's Enrollee population and community,

including:

a. A brief description of the population of Enrollees the Contractor serves and the communities in which they live;

b. A description of the characteristics of such population and communities, including at a minimum:

1) The approximate number of Enrollees in the population;

2) The population's demographic characteristics, including but not limited to age, race, ethnicity, languages spoken, disability status, sexual orientation, gender identity, and;

3) A description of any other salient characteristics of the population that inform the Contractor's strategy for improving the quality and cost of Enrollee care, such as any particular public or environmental health concerns.

c. A description of the health, functional, and other care needs of such population and communities, including but not limited to:

1) A list and description of prevalent conditions in the population, including chronic diseases;

2) A description of the population's behavioral health needs;

3) A description of the population's LTSS needs; and

4) A description of the population's health-related social needs.

d. A description of the community resources that currently exist in such communities.

2. The Contractor shall submit its initial Population and Community Needs Assessment by the Contract Operational Start Date, and shall conduct an updated Population and Community Needs Assessment prior to the start of Contract Year 3.

3. The Contractor must submit this Population and Community Needs Assessment upon EOHHS request

4. The Contractor may leverage existing community needs assessments, including those required of FQHCs and hospitals, to develop its Population and Community Needs Assessment, as long as the assessment meets the requirements of this **Section 2.21.B**.

C. Health Equity Strategic Plan and Reporting

1. The Contractor, with input from its Health Equity Committee, shall create, monitor, and

update as needed a five-year Health Equity Strategic Plan, which shall be submitted to EOHHS for review and approval in accordance with **Appendix A**. In developing the Contractor's Health Equity Strategic Plan, the Contractor shall seek input from the Health Equity Committee, Providers representing the composition of the Contractor's Provider Network such as community hospitals, other community-based providers, Community Partners, Enrollees, and Enrollees' families.

2. The plan shall describe:

   a. How the Contractor sought and incorporated input from the Health Equity Committee, Providers representing the composition of the Contractor's Provider Network such as community hospitals, other community-based providers, Community Partners, Enrollees, and Enrollees' families;

   b. How the Contractor partners with hospitals affiliated with the Contractor for the purposes of the Hospital Health Equity incentive program to further joint Health Equity goals, including a description of joint priorities and how they were determined, as well as joint governance over any included workstreams.

   c. The Contractor's approaches to establishing a culture of equity that recognizes and prioritizes the elimination of inequities through respect, fairness, cultural competency, and advocacy, including through the provision of trainings for Health Equity, implicit bias, anti-racism, and related trainings to all staff (contracted or directly employed) that interact with Medicaid enrollees;

   d. The Contractor's approach to ensure all Contractor policy and procedures consider health inequities and are designed to promote Health Equity where possible and in accordance with all federal and state law, including but not limited to: 1) marketing strategy; 2) enrollment and disenrollment, 3) medical, behavioral health, and other health services policies; 4) enrollee and provider outreach; 5) PFACs; 6) grievances and appeals; 7) utilization management; and 8) the Flexible Services program;

   e. How the Contractor used its Population and Community Needs Assessment to inform the plan;

   f. The Contractor's planned approaches to maintaining robust structures to identify and understand inequities to support the implementation of evidence-based interventions, including to:

      1) Engage Enrollees and communities to inform Health Equity initiatives;

      2) Achieve complete and comprehensive member-reported social risk factor data as further specified by EOHHS (e.g., race, ethnicity, language, disability, sexual orientation, gender identity, health-related social needs)

3) Report on performance measures including but not limited to the ACO Quality Measures, stratified by social risk factors, which may include but are not limited to race, ethnicity, language, disability, sexual orientation, and gender identity

g. The Contractor's planned interventions to reduce inequities, including how it will:

1) Collaborate and partner with other sectors that influence the health of individuals;

2) Ensure equitable access to healthcare;

3) Deliver high-quality care that continuously reduces inequities.

h. The Contractor's targeted Health Equity-related milestones, including Quality Measure-specific disparity reduction targets for each year of the Contract and for the entire five-year Contract; and

i. Specific Quality Measures specified by EOHHS stratified by race, ethnicity, and other social risk factors as further specified by EOHHHS the Contractor will use to monitor progress towards Health Equity goals. Contractors may also choose to use additional Health Equity performance metrics. For each stratified quality metric, the Contractor shall describe:

1) Baseline value, or an explanation of why a baseline value is not available

2) Annual improvement target(s) that are specific, measurable, actionable, and relevant goal values

3) Five-year improvement target(s) that are specific, measurable, actionable, and relevant

4) Which planned interventions support progress towards improvement targets and how they will support such progress.

3. The Contractor shall include in the plan an executive summary, in a form and format as further specified by EOHHS, and include an overview of all the key sections of the plan;

4. In accordance with **Appendix A**, the Contractor shall regularly report to EOHHS, in a form and format as further specified by EOHHS, on items related to its Health Equity Strategic Plan, including but not limited to:

a. Any modifications to the organization's Health Equity Strategic Plan

b. Health Equity Committee composition, activities, and how MassHealth Enrollee and front-line staff feedback is incorporated into decision making processes or

otherwise utilized as part of the Health Equity work;

c. PFAC composition, summary of activities, and a summary of how consumer feedback is utilized;

d. Progress towards targeted milestones and any other achievements in the preceding year and since the beginning of the contract period related to:

1) Establishing a culture of equity, including reporting on Health Equity, anti-racism, implicit bias, and related staff trainings, as described in **Section 2.21.D**.

2) Establishing necessary structures and partnerships (including but not limited to, with community providers and community hospitals) to support Health Equity

3) Developing necessary capacity to report on key performance indicators stratified by social risk factors including but not limited to race, ethnicity, language, disability, sexual orientation, and gender identity

e. State of implementation of cultural competence/CLAS standards (see **Section 2.21.E**);

f. Progress towards targeted milestones in the preceding year and since the beginning of the contract period on implementing interventions related to:

1) Collaborating and partnering with other sectors that impact the health of individuals

2) Ensuring equitable access

3) Delivering high quality care that continuously reduces inequities

4) Other interventions to reduce health inequities experienced by MassHealth Enrollees

g. Progress towards annual improvement targets for specified Health Equity improvement key performance indicators, supplemented by a description of what contributed to successful achievement of annual targets.

h. Gaps in achievement of targeted annual Health Equity Strategic Plan goals, observed barriers to achieving goals, and specific plans for the upcoming year to overcome such gaps.

5. At EOHHS's request, the Contractor shall meet with EOHHS to discuss its reporting on items in this **Section 2.21.C.4**;

6. The Contractor shall publicly post the executive summaries of its Health Equity Strategic Plan and its annual Health Equity summary reports on its website, and make these documents available to EOHHS for posting on EOHHS' website;

D. Health Equity, Anti-Racism, Implicit Bias, and Related Trainings

The Contractor shall ensure that meaningful and appropriate trainings to advance Health Equity are periodically received by all staff and Network Providers (contracted or directly employed) that interact with Medicaid Enrollees (through operations, delivery of services, or other patient interfacing roles (e.g., security officer or receptionist)), in accordance with **Section 2.9.**J and as further specified by EOHHS.

E. Culturally and Linguistically Appropriate Services

1. The Contractor shall ensure its Provider Network provides Culturally and Linguistically Appropriate Services (CLAS) to Enrollees.

2. In accordance with its reporting under **Section 2.21.C**, the Contractor shall describe how it ensures that Enrollees receive Culturally and Linguistically Appropriate Services. The Contractor shall describe how it intends to assess and address the needs of the population and communities it intends to serve, including:

    a. The linguistic accessibility needs of its Enrollee population, including Enrollees' preferred languages, the needs of Enrollees who are Deaf or hard of hearing, and Enrollees' needs related to health literacy. Such linguistic accessibility shall also include access to the Contractor's Provider Network via newer communication modalities, including telehealth.

    b. The cultural accessibility needs of its Enrollee populations;

    c. The needs of Enrollees for accessible medical and diagnostic equipment;

    d. The process utilized to verify that their Provider directories accurately capture member accommodations capabilities; and

    e. Demonstrating current adoption of national CLAS standards within the organization and propose how it shall further develop CLAS and evaluate gaps in achieving CLAS, including:

        1) Training and assessing staff for cultural competencies, including name of training curriculum, if any;

        2) Selecting a CLAS Champion (any individual, clinical or non-clinical, who is knowledgeable about CLAS Standards and can serve as a subject matter expert to support and train others)

3. The Contractor shall have clear and user-friendly processes and policies in place for

Enrollees to request linguistic interpreters and other linguistic or physical accommodations. The Contractor shall, at a minimum, post such policies on its Contractor's website and include such policies in its Enrollee Handbooks as set forth in **Section 2.11.D**. They shall also offer this option on their customer service lines, including understanding processes for how to request interpreter services and accommodations. The Contractor shall include a description of Enrollee rights including but not limited to those Enrollee rights described in **Section 5.1.L** in its Enrollee Handbooks and on its website.

4. The Contractor shall complete a CLAS Standards self-evaluation annually, which can be used as a quality improvement tool to support efforts to implement CLAS and to assess performance and continuous improvement. The Self-Evaluation shall include the following metrics:

    a. The percentage of calls conducted in a language other than English, the percentage of Enrollee-facing materials available in languages other than English, number of languages available for real-time interpreter services

    b. Number and types of language or accommodation requests, including any denials

    c. Number of grievances on this topic and/or related to discrimination based on race, ethnicity, language, disability, sexual orientation, gender identity or other characteristics

    d. Number of staff who receive training in culturally and linguistically appropriate service delivery

    e. Member satisfaction data to inform culturally and linguistically appropriate services

5. The Contractor shall take immediate action to improve the delivery of CLAS when deficiencies are identified.

F. Health Equity Incentive

1. The Contractor shall participate in the ACO Health Equity Incentive Arrangement, as set forth in **Section 4.6.B** and **Appendix Q**.

2. The Contractor shall identify any Health Equity Partner Hospitals to EOHHS in accordance with **Appendix A**.

G. National Committee on Quality Assurance (NCQA) Health Equity Accreditation

The Contractor shall:

1. By end of Contract Year 2, be accredited by the National Committee on Quality Assurance (NCQA) for its Health Equity Accreditation program at the Accountable Care

Partnership Plan level;

2. Annually, inform EOHHS if it is nationally accredited through NCQA or if it has sought and been denied such accreditation;

3. As directed by EOHHS, submit a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any to EOHHS; and

4. Authorize NCQA to provide EOHHS a copy of the Contractor's most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings, and expiration date of accreditation.

H. Data Collection

The Contractor shall ensure that every Enrollee is given an opportunity to update their social risk factor data (e.g., race, ethnicity, language, disability, sexual orientation and gender identity) as requested.

Section 2.22 Contractor COVID-19 Efforts

As further specified by EOHHS, the Contractor shall help manage the 2019 novel Coronavirus (COVID-19) as set forth in this section, in MassHealth bulletins, including but not limited to MassHealth managed care entity bulletins, and other MassHealth guidance. Such activities to help manage COVID-19 shall include but may not be limited to:

A. Taking all necessary steps to enable Enrollees to obtain medically necessary and appropriate testing and treatment.

B. Delivering all ACO Covered Services in an amount, duration and scope that is no more restrictive than the MassHealth fee-for-service program and staying up to date on any changes to the amount, duration, and scope of services that MassHealth may announce via bulletins or guidance.

C. Conforming coverage policies of COVID-19 testing, treatment, and prevention, vaccines and vaccine counseling services, including specific coding and payment policies, with that of MassHealth through its fee-for-service program.

D. Communicating, with EOHHS prior approval, relevant benefits, prevention, screening, testing, and treatment options to Enrollees and guidelines for contacting an Enrollee's local board of health or health care provider.

E. Covering outpatient COVID-19 testing, evaluation, and treatment services provided by out-of-network providers, as well as follow-up care provided by out-of-network providers when such follow-up care is not available in the Contractor's Provider Network.

Section 2.23 Other ACO Responsibilities

A. Primary Care Sub-Capitation Program

1. Primary Care Sub-Capitation Program Requirements

The Contractor shall implement the Primary Care Sub-Capitation Program as follows and as further specified by EOHHS:

a. Ensure that all participating Network PCPs participate in the Primary Care Sub-Capitation Program as described in this Section;

b. As further specified by EOHHS, designate each Network Primary Care Practice PID/SL as meeting the care model requirements of Primary Care Sub-Capitation Tier 1, 2, or 3, as set forth in **Appendix K**;

c. Ensure that Network Primary Care Practice PID/SLs that are FQHCs meet the Tier Designation criteria for Tier 3, as described in **Appendix K,** and participate in the Primary Care Sub-Capitation Program with a Tier Designation of Tier 3; provided however that a FQHC Practice PID/SL may participate with a Tier Designation of Tier 1 or Tier 2 with written approval from EOHHS;

d. Ensure that all Network Primary Care Practice PID/SLs meet the requirements of their designated Tier as follows and as further specified by EOHHS:

1) All Network Primary Care Practice PID/SLs with a Tier Designation of Tier 1 in shall fulfill all Tier 1 requirements as described in **Appendix K**.

2) All Network Primary Care Practice PID/SLs with a Tier Designation of Tier 2 in shall fulfill all Tier 1 and Tier 2 requirements as described in **Appendix K**.

3) All Network Primary Care Practice PID/SLs with a Tier Designation of Tier 3 in shall fulfill all Tier 1, Tier 2, and Tier 3 requirements as described in **Appendix K**.

e. For each Network Primary Care Practice PID/SL, maintain at all times a copy of **Appendix K, Exhibit 1** signed by both the Contractor and the corresponding Primary Care Practice PID/SL;

f. As further specified by EOHHS, comply with all program integrity and audit activities related to the Primary Care Sub-Capitation Program.

g. Comply with all reporting and data requirements related to the EOHHS Primary Care Sub-Capitation Program as further specified by EOHHS

h. As follows and as further specified by EOHHS, make monthly, prospective payments to Primary Care Entities (PCEs) for the delivery of a defined set of services for Primary Care and behavioral health integration (Primary Care Sub-

Capitation Included Services):

1) For each Primary Care Entity, make a monthly payment, based on enrollment, at a rate that is no less than 90% of the rate set forth for such PCE in **Appendix L** except as set forth in this **Section.**

2) For each PCE that is a FQHC, , make a monthly payment, based on enrollment, at a rate that is no less than 100% of the rate set forth for such PCE in **Appendix L**.

3) Ensure that PCEs allocate such payments regularly to each Network Primary Care Practice PID/SL based on:

   a) The Tier Designation for that Network Primary Care Practice PID/SL; and

   b) The acuity of the Enrollees attributed to that Network Primary Care Practice PID/SL relative to other Network Primary Care Practice PID/SLs within the PCE.

4) Ensure that payments under the Primary Care Sub-Capitation Program are distributed in accordance with **Section 2.23.A** and are not based on Enrollees' utilization of services.

5) Report to EOHHS on the Contractor's Primary Care Sub-Capitation Program payments in a form, format, and frequency specified by EOHHS.

i. The Contractor shall:

1) Ensure that Network Primary Care Practice PID/SLs submit claims for Primary Care Sub-Capitation Included Services as further specified by EOHHS;

2) Adjudicate such claims according to the Primary Care Sub-Capitation Program claims logic, as specified by EOHHS; provided however that the Contractor may adjudicate such claims according to a logic that differs from EOHHS' specified logic with prior written approval from EOHHS;

3) Pay such claims that meet the requirements of the claims logic at a rate of zero (0) dollars;

4) Ensure information about such claims is submitted in the Encounter data as further specified by EOHHS.

2. Annually pay a total amount in aggregate to all Network Primary Care Practice PID/SLs for the Primary Care Sub-Capitation Included Services that is no less than the sum of

each PCE's individual rate, as specified in **Appendix L**, multiplied by the PCE's actual member months.

3. If applicable, the Contractor shall coordinate with its Behavioral Health material Subcontractor to ensure the requirements of this **section** are met

4. The Contractor shall report to EOHHS on its payment methodology and arrangements with its participating PCPs related to its implementation of the EOHHS Primary Care Sub-Capitation Program, in accordance with **Appendix A** and as further specified by EOHHS.

B. Flexible Services Program

1. Flexible Services Program Requirements

The Contractor shall:

a. Implement at least one Flexible Services program in each of the tenancy and nutrition domains, at a minimum;

b. Employ sufficient, appropriate administrative staff dedicated to Flexible Services activities for the purposes of:

1) Completing all requirements as laid out in this **Section 2.24** of this Contract

2) Oversight and administration of the Flexible Services program including liaising with EOHHS and serving as the point of contact for all EOHHS communications related to Flexible Services;

3) Collaboration with practice sites to establish, launch, and maintain Flexible Services programs;

4) Timely responsiveness to any EOHHS requests for information, reports, analysis, or other materials related to the Flexible Services program;

5) Budgeting and spending of at least 75% of their Flexible Services Allocation for the Contract Year, or a different amount as further specified by EOHHS

c. Develop, implement, and maintain processes for collecting, sharing, and reporting Flexible Services member data and analytics with EOHHS and relevant partners.

d. Utilize electronic systems (e.g., secure e-mail, secure file transfer protocol, electronic platform) to refer Enrollees to Social Services Organizations for Flexible Services and follow up with Social Services Organizations post-referral.

e. Ensure that at least 1% of Enrollees are participating in the Flexible Services

program, as specified by EOHHS. To assess Enrollee participation in the Flexible Services program annually (or at another frequency or time specified by EOHHS) EOHHS shall divide a count of unique Enrollees receiving Flexible Services in the previous year (or other period specified by EOHHS), as determined by EOHHS, by a count of unique Enrollees in the Contractor's plan during the same specified time period, as specified by EOHHS.

f. Ensure that the percentage of Enrollees up to age 21 participating in Flexible Services is roughly proportional to the overall percentage of the Contractor's Enrollees up to age 21. To assess the participation of Enrollees up to age 21 in the Flexible Services program annually (or at another frequency or time specified by EOHHS), EOHHS shall:

   1) Divide a count of unique Enrollees up to age 21 receiving Flexible Services in the previous year (or other period specified by EOHHS), as determined by EOHHS, by a count of total unique Enrollees receiving Flexible Services at any time during the same specified time period, as determined by EOHHS;

   2) Divide a count of unique Enrollees up to age 21 in the Contractor's plan, as determined by EOHHS, by a count of total unique Enrollees in the Contractor's plan, as determined by EOHHS, during the same specified time period; and

   3) Compare the results in **Sections 2.23.B.1.f.1** and **2.23.B.1.f.2** above.

g. Budget and spend at least 75% of the Contractor's total Flexible Services allocation for the Contract Year. The Contractor shall roll over no more than 25% of their yearly Flexible Services allocation between Contract Years.

h. Ensure that at least one of their Flexible Services programs is aligned with their Health Equity Strategic Plan as described in **Section 2.21**.

i. Have a plan to address potential disparities in access to and outcomes from Flexible Services, as further specified by EOHHS.

j. Ensure that Enrollees receiving Flexible Services are notified of any changes to Flexible Services supports, including if the Contractor is ending a Flexible Services Program or when a Contractor is discontinuing Flexible Services that the Enrollee is engaged in, if applicable.

2. Flexible Services Screening and Flexible Services Plan

The Contractor shall ensure that a Flexible Services screening and a Flexible Services plan are completed for each Enrollee receiving Flexible Services as follows and as further specified by EOHHS:

a. Flexible services screenings and plans shall be conducted, documented in writing, agreed to by the Enrollee, and approved by the Contractor prior to the delivery of any Flexible Services.

b. The Contractor shall have at least one in-person meeting with the Enrollee during the assessment and planning process. The in-person assessment and planning may include telehealth (e.g., telephone or videoconference), provided that:

1) The Enrollee has provided informed consent to receive assessments and planning performed by telehealth;

2) Such informed consent is documented by the Enrollee; and

3) The Enrollee receives the support needed to have the assessment conducted via telehealth (including any on-site support needed by the Enrollee).

c. An Enrollee's Flexible Services screening shall be conducted using screening tools and methods that align with approved program eligibility requirements, as further specified by EOHHS;

d. An Enrollee's Flexible Services plan shall describe Flexible Services specific to the Enrollee's needs, as identified by the Enrollee's Flexible Services screening;

e. A Flexible Services plan approved by the Enrollee and the Contractor is valid for up to 12 months from the date of approval by the Contractor;

f. The Contractor shall establish and maintain a review process for Flexible Services plans, including standard review and expedited review; and

g. The Contractor shall maintain Flexible Services screening, planning, and referral information for each Enrollee in a form and format specified by EOHHS and shall provide EOHHS with such information upon request.

h. The Contractor shall ensure that, at a minimum, appropriate Flexible Services have been delivered to Enrollees with approved Flexible Services plans.

3. Flexible Services Participation Plan

a. At all times during the contract term, the Contractor shall maintain an EOHHS-approved Flexible Services Participation Plan, in a form and format specified by EOHHS and as described in this section. As further specified by EOHHS, the Contractor's Flexible Services Participation Plan and its spending plan, shall include, at a minimum the following:

1) A description of the specific Flexible Services programs the Contractor

will support with Flexible Services funds. Such Flexible Services programs shall fit within EOHHS-approved categories of Flexible Services, as further specified by, and which may be updated from time to time by, EOHHS. Such EOHHS-approved categories are:

a) Tenancy Preservation Supports; and

b) Nutrition Sustaining Supports;

2) A description of how the Contractor used its Population and Community Needs Assessment as set forth in **Section 2.21.B** to inform its approach for its Flexible Services programs.

3) The Contractor's target populations for its Flexible Services program(s);

4) The Contractor shall ensure its Flexible Services program(s) do not duplicate other Federal, State, or other publicly funded programs.

5) Specific goals and evaluation plans for the Contractor's Flexible Services program(s), as further specified by EOHHS;

6) A description of how the Contractor plans to address potential disparities in access to and outcomes from Flexible Services, as further specified by EOHHS; and

7) A description of the Contractor's sustainability plan for its Flexible Services programs;

b. The Contractor shall submit its Flexible Services Participation Plan to EOHHS for approval within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

c. The Contractor shall update and resubmit its Flexible Services Participation Plan to EOHHS for approval upon any significant anticipated changes in the Contractor's future activities or programs under its Flexible Services Participation Plan as follows or as otherwise requested by EOHHS:

1) For any significant anticipated changes in the Contractor's future activities or programs identified by the Contractor, the Contractor shall update and resubmit its Flexible Services Participation Plan to EOHHS for approval, provided however that the Contractor may not request modification to its Flexible Services Participation Plan within 75 calendar days of the end of the current Contract Year;

2) The Contractor's Flexible Services Participation Plan shall be subject to review and approval by EOHHS. EOHHS may withhold the Contractor's Flexible Services payment until EOHHS approves the Contractor's

Flexible Services Participation Plan;

4. Flexible Services Budget and Budget Narratives

The Contractor shall submit Flexible Services Budgets and Budget Narratives to EOHHS as follows:

a. The Budget and Budget Narrative shall be in form and format specified by EOHHS;

b. The Contractor shall submit the Budget and Budget Narrative annually for each Contract Year, within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

c. The Contractor shall update and resubmit its Budget and Budget Narrative to EOHHS for approval upon any significant anticipated changes in the Contractor's future activities or programs under its Budget and Budget Narrative as follows or as otherwise requested by EOHHS:

1) For any significant anticipated changes in the Contractor's future activities or programs identified by the Contractor, the Contractor shall update and resubmit its Budget and Budget Narrative to EOHHS for approval, provided however that the Contractor may not request modification to its Budget and Budget Narrative within 75 calendar days of the end of the current Contract Year;

2) For any significant anticipated changes in the Contractor's future activities or programs identified by EOHHS, the Contractor shall submit its modified budget and budget narrative to EOHHS for approval within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

d. The Budget shall show how the Contractor proposes to spend Flexible Services allocation on the Contractor's Flexible Services program(s) for the Contract Year, and the Budget Narrative shall describe how this spending will support Contractor's Flexible Services Participation Plan and Contractor's activities under this Contract.

e. EOHHS may withhold the Contractor's Flexible Services payment until EOHHS approves the Contractor's Budget and Budget Narrative for that Contract Year;

5. Flexible Services Progress Reports

The Contractor shall submit Flexible Services Progress Reports to EOHHS as follows:

a. The Progress Reports shall be in form and format specified by EOHHS;

b. Contractor shall submit the Progress Reports semiannually, or at another

frequency specified by EOHHS;

c. The Progress Reports shall describe Contractor's activities under Contractor's Flexible Services Participation Plan and under this Contract, including challenges, successes, and requested modifications to the Participation Plan and other information, as further specified by EOHHS;

d. The Progress Reports shall contain updated financial accountings of the Contractor's spending of Flexible Services payments;

e. As further specified by EOHHS, the Progress Reports shall contain numbers of Enrollees screened eligible for Flexible Services, the number of Enrollees approved for Flexible Services that were referred to entities delivering Flexible Services, and other relevant information as specified by EOHHS;

f. Based on Enrollees that received Flexible Services, Progress Reports shall include an equity analysis to identify any potential disparities in access to Flexible Services and outcomes from Flexible Services, as specified by EOHHS.

g. The Progress Reports shall be subject to modification and approval by EOHHS;

h. EOHHS may withhold the Contractor's Flexible Services payment until EOHHS approves the Contractor's to-date Progress Reports; and

i. EOHHS may reduce the Contractor's future Flexible Services allocation or otherwise recoup payment from the Contractor, in accordance with **Section 5.4.G**, if, upon review of the financial accountings contained in such Progress Reports, EOHHS determines that Contractor has not spent all the Contractor's Flexible Services payments in accordance with the Contractor's Flexible Services Participation Plan or with the requirements of this Contract;

6. Contractor's Community Partners (CPs) and Flexible Services

a. At a minimum, the Contractor shall inform a CP when the Contractor's CP Enrollees receive Flexible Services, in a form and format specified by EOHHS.

7. Other Requirements for Flexible Services

a. The Contractor shall pay Social Service Organizations delivering Flexible Services within forty-five (45) calendar days of receiving an invoice, if paying retrospectively.

b. The Contractor shall ensure that all Flexible Services are provided by individuals who have education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field, or at least 1 year of relevant professional experience or training in the field of service; and have knowledge

of principles, methods and procedures of such services, as further specified by EOHHS.

c. The Contractor shall ensure that entities delivering Flexible Services that also perform Flexible Services planning, verification, or screening for Flexible Services eligibility take appropriate steps to avoid conflicts of interest, as further specified by EOHHS.

d. The Contractor shall report to EOHHS on a quarterly basis describing the Contractor's Enrollees that have received Flexible Services, as well as Enrollees screened for services that did not receive services in a form and format specified by EOHHS.

e. As further specified by EOHHS, the Contractor shall submit Flexible Services member facing materials and other relevant materials prior to launching each individual Flexible Services program.

f. The Contractor shall have a point of contact for all Social Services Organizations with which it has contracted to deliver Flexible Services or perform administrative functions.

8. Use of Flexible Services Payment Information

The Contractor shall ensure and demonstrate to EOHHS' satisfaction that the Contractor's Flexible Services payments are spent as follows:

a. The Contractor shall spend its Flexible Services payments in accordance with the Contractor's EOHHS-approved Flexible Services Participation Plan, Progress Reports, Budgets, and Budget Narratives;

b. The Contractor shall ensure that its Flexible Services payments are not duplicative with funding available through other publicly available programs.

9. Flexible Services Payments

Subject to other terms and conditions of the Contract, including but not limited to EOHHS' receipt of all necessary federal and state approvals, EOHHS shall pay the Contractor Flexible Services payments as follows:

a. EOHHS shall determine a per-Enrollee Flexible Services Allocation for each Contract Year;

b. EOHHS shall calculate the number of Enrollees to use in determining the Contractor's total Flexible Services Allocation each Contract Year based on a schedule determined by EOHHS, as further specified by EOHHS;

c. EOHHS shall make such payments each Contract Year in four equal quarterly

installments, or at another frequency and in other divisions specified by EOHHS. Installment amounts will depend on the Contractor's approved Flexible Services programs. Flexible Services payments shall be used for services that meet the following requirements, in EOHHS' sole determination:

1) Fit into an EOHHS-approved category of Flexible Services as described in **Appendix M**.

2) Are health-related;

3) Are not otherwise MassHealth covered services under the Massachusetts state plan, the MassHealth 1115 Demonstration Waiver, or other publicly-funded programs, including Home and Community-Based Waiver programs;

4) Are provided to Flexible Service eligible Enrollees, as described in **Appendix M**;

5) Are consistent with and documented in the Enrollee's Flexible Service plan;

6) Are determined to be informed by evidence that the service may reduce total cost of care and health disparities and either improve health outcomes or prevent worsening of health outcomes, in EOHHS' sole determination; and

7) Meet any additional requirements specified by EOHHS;

d. If the Contract is terminated, then the Contractor shall return to EOHHS any unspent Flexible Services payments within 30 calendar days of the end of the Contract. Furthermore, the Contractor shall not receive any additional Flexible Services Payments after a notification of termination has been provided by either EOHHS or the Contractor.

10. Conditions

All Flexible Services payments are subject to federal approval and availability of funds. EOHHS reserves the right to reduce the amount of Flexible Services payments or to recoup some part of the Flexible Services payments if available funds are reduced including but not limited to if federal authority for the Flexible Services program is reduced;

11. Defer Flexible Services Payment

EOHHS may defer making a Contract Year's Flexible Services payments by up to one year from the end of such Contract Year, as further specified by EOHHS, including but not limited to due to the availability of funds.

12. Failure to Meet Requirements of This Section

As further specified by EOHHS, if the Contractor does not meet the requirements of this **Section 2.23.B,** EOHHS may reduce the Contractor's Flexible Services allocation or further limit the amount of Flexible Services allocation the Contractor may roll over in accordance with **Section 5.4.G.**

SECTION 3. EOHHS RESPONSIBILITIES

Section 3.1 Contract Management

A. Administration

EOHHS shall:

1. Designate an individual authorized to represent EOHHS regarding all aspects of the Contract. EOHHS' representative shall act as a liaison between the Contractor and EOHHS during the Contract Term. The representative shall be responsible for:

    a. Monitoring compliance with the terms of the Contract;

    b. Receiving and responding to all inquiries and requests made by the Contractor under this Contract;

    c. Meeting with the Contractor's representative on a periodic or as needed basis for purposes including but not limited to discussing issues which arise under the Contract; and

    d. Coordinating with the Contractor, as appropriate, on Contractor requests for EOHHS staff to provide assistance or coordination on Contractor responsibilities;

2. Review, approve and monitor the Contractor's outreach and orientation materials, MassHealth Member Handbook, Marketing Materials, wellness program materials, and Complaint, Grievance and Appeals procedures.

3. If it determines that the Contractor is in violation of any of the terms of the Contract stated herein, at its sole discretion, apply one or more of the sanctions provided in **Section 5.4.A.2**, including termination of the Contract in accordance with **Section 5.6**; provided, however, that EOHHS shall only impose those sanctions that it determines to be reasonable and appropriate for the specific violation(s) identified;

4. At its discretion, conduct annual validity studies to determine the completeness and accuracy of Encounter Data including comparing utilization data from medical records of Enrollees (chosen randomly by EOHHS) with the Encounter Data provided by the Contractor. If EOHHS determines that the Contractor's Encounter Data are less than 99% complete or less than 95% accurate, EOHHS will provide the Contractor with written documentation of its determination and the Contractor shall be required to implement a corrective action plan to bring the accuracy to the acceptable level. EOHHS may conduct a validity study following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Contractor has attained 99% completeness. EOHHS, at its discretion, may impose intermediate sanctions or terminate the Contract if the Contractor fails to achieve a 95% accuracy level following completion of the corrective action plan as determined by the validity study or as otherwise determined by EOHHS;

5. At its discretion, conduct periodic on-site visits as described under **Sections 2.18** and 6.4 of this Contract. At the time of such visits, the Contractor shall assist EOHHS in activities pertaining to an assessment of all facets of the Plan's operations including, but not limited to, financial, administrative, clinical, utilization and Network Management, pharmacy and claims processing functions and the verification of the accuracy of all data submissions to EOHHS as described herein;

6. If it determines that the Contractor is out of compliance with **Section 5.1.G** of the Contract, notify the Secretary of such non-compliance and determine the impact on the term of the Contract in accordance with **Section 5.6** of the Contract; and

7. EOHHS shall notify the Contractor, as promptly as is practicable, of any Providers suspended or terminated from participation in MassHealth so that the Contractor may take action as necessary, in accordance with **Section 2.9.H**.

B. Performance Evaluation

EOHHS shall, at its discretion:

1. Annually review the impact and effectiveness of the Quality Management/Quality Improvement program by reviewing the results of performance improvement projects, performance on standard measures, and all other quality initiatives specified in **Section 2.14.C**.

2. On an ongoing basis, monitor and evaluate the Contractor's compliance with the terms of this Contract, including, but not limited to, the reporting requirements in **Appendix A** and the performance measurement and performance improvement projects set forth in **Sections 2.14.C** and **Appendix B**, and shall at its discretion, monitor and evaluate any or all of the Contractor's operational processes and metrics that indicate the Contractor's organizational health. EOHHS will provide the Contractor with the written results of such evaluations, including, at its discretion, a quarterly scorecard that shows how the Contractor has performed relative to its own previous quarter's performance and relative to the Accountable Care Partnership Plan average. EOHHS will also, at its discretion, provide the Contractor with an annual score for the reports submitted in accordance with **Appendix A** and a biennial score for the reports submitted in accordance with **Appendix B**.

3. Conduct periodic audits of the Contractor, as further described in **Section 5.5**, including, but not limited to, annual External Quality Review Activities, as specified in **Section 2.14.C.2**, and an annual operational review site visit pursuant to **Section 2.18**.

4. Conduct biennial Member satisfaction surveys and provide the Contractor with written results of such surveys.

5. Evaluate, in conjunction with the U.S. Department of Health and Human Services, through inspection or other means, the quality, appropriateness, and timeliness of services performed by the Contractor and all Network Providers.

Section 3.2 Coordination of Benefits

A. EOHHS shall, via the HIPAA 834 Outbound Enrollment file, provide the Contractor with all third-party health insurance information on Enrollees where it has verified that third party health insurance exists.

B. EOHHS shall refer to the Contractor the Enrollee's name and pertinent information where EOHHS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

C. EOHHS shall develop Base Capitation Rates that are net of expected TPL recoveries, consistent with the Contractor's obligation under this Contract, including **Section 2.20**, to recover claims paid to Providers where the other insurer was primary.

Section 3.3 Enrollment, Assignment, and Disenrollment Process

A. Enrollment Verification

EOHHS shall verify and inform the Contractor of each Enrollee's eligibility and enrollment status in the Contractor's Plan, through the Eligibility Verification System (EVS) and through the HIPAA 834 Outbound Enrollment file.

B. Enrollment

EOHHS shall:

1. Maintain sole responsibility for the enrollment of Members into the Contractor's Plan, as described in this **Section 3.3**. EOHHS shall present all options available to Members under MassHealth in an unbiased manner and shall inform each Member at the time of enrollment, of their right to terminate enrollment at any time;

2. On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Daily Enrollment file, information pertaining to all enrollments, including the Effective Date of Enrollment, which will be updated on a daily (business day) basis;

3. At its discretion, automatically re-enroll on a prospective basis in the Contractor's Plan, Members who were disenrolled due to loss of eligibility and whose eligibility was reestablished by EOHHS;

4. Make best efforts to provide the Contractor with the most current demographic information available to EOHHS. Such demographic data shall include, but is not limited to, when available to EOHHS, the Enrollee's name, address, MassHealth identification number, date of birth, telephone number, race, gender, ethnicity, and primary language; and

5. Review and respond to written complaints from the Contractor about EOHHS' Enrollment Broker within a reasonable time. EOHHS may request additional information from the Contractor in order to perform any such review.

C. Disenrollment

1. Disenrollment Conditions

a. EOHHS shall disenroll an Enrollee from the Contractor's Plan and they shall no longer be eligible for services under such Plan following:

1) Loss of MassHealth eligibility;

2) Completion of the Enrollee's voluntary disenrollment request;

3) EOHHS approval of a request by the Contractor for involuntary disenrollment pursuant to **Section 2.4.D** herein; or

4) Loss of eligibility for MassHealth Managed Care as indicated in 130 CMR 508.002 which includes but is not limited to Enrollees receiving continuing inpatient psychiatric care.

b. Except as otherwise provided under federal law or waiver, an Enrollee may disenroll voluntarily:

1) For cause, at any time, in accordance with 42 CFR 438.56(d)(2) and 130 CMR 508.003(C)(3); and

2) Without cause, at any time during a plan selection period as set forth in 130 CMR 508.003(C)(1)

2. Disenrollment Information

EOHHS shall:

a. On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Enrollment File, information pertaining to all disenrollments, including the Effective Date of Disenrollment and the disenrollment reason code; and

b. Provide the Contractor with information related to the following voluntary disenrollment reasons as received from Enrollees by EOHHS' Enrollment Broker on a monthly basis. Such disenrollment reasons may include, but are not limited to:

1) Difficult to contact PCP;

a) Takes too long to obtain an appointment;

b) Did not like the PCP;

c) Dissatisfaction with Behavioral Health Services;

d) Did not like office staff's personal manner;

e) Received poor medical treatment; and

f) Any other specified causes.

Section 3.4 Customer Service Center (CSC) Vendor

EOHHS or its designee shall:

A. Develop generic materials to assist Members in choosing whether to enroll in the Contractor's Plan, another Accountable Care Partnership Plan, an MCO, or the PCC Plan. Said materials shall present the Contractor's Plan in an unbiased manner to Members eligible to enroll in the Contractor's Plan. EOHHS may collaborate with the Contractor in developing Plan-specific materials;

B. Present the Contractor's Plan in an unbiased manner to Members in the Contractor's Service Area(s) who are newly eligible for Managed Care or seeking to transfer from one Managed Care plan to another plan. Such presentation(s) shall ensure that Members are informed prior to enrollment of the following:

1. The nature of the requirements of participation in an Accountable Care Partnership Plan, including but not limited to:

   a. Use of Network Providers;

   b. Maintenance of existing relationships with Network Providers; and

   c. The importance of Primary Care;

   d. The nature of the Contractor's medical delivery system, including, but not limited to the Provider Network; ability to accommodate non-English-speaking Enrollees; referral system; and, requirements and rules which Enrollees shall follow once enrolled in the Contractor's Plan; and

   e. Orientation and other Member services made available by the Contractor;

2. Enroll, disenroll and process transfer requests of Enrollees in the Contractor's Plan, including completion of EOHHS's enrollment and disenrollment forms, except enrollment forms for newborn Enrollees;

3. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment under MassHealth regulations, and federal law or waiver;

4. Be knowledgeable about the Contractor's policies, services, and procedures;

5. At its discretion, develop and implement processes and standards to measure and

improve the performance of the CSC Vendor staff. EOHHS shall monitor the performance of the CSC Vendor; and

6. Invite all MassHealth-contracted Accountable Care Partnership Plans in the Service Area to participate in EOHHS-sponsored Health Benefit Fairs.

Section 3.5 Marketing

EOHHS shall:

A. Monitor the Contractor's Marketing activities and distribution of related materials; and

B. Within fifteen (15) business days of receipt of Marketing Material submitted by the Contractor in compliance with **Section 2.12.A.3**, take one of the following actions:

1. Approve or disapprove the Marketing Material;

2. Require modification to the Marketing Material; or

3. Notify the Contractor that EOHHS requires an additional ten (10) business days from the date of such notification to take the actions described in **B.1 or B.2** above.

The Contractor shall comply with any such EOHHS action. EOHHS's failure to take any of the actions described in **Section 3.5.B.1-3** above within 30 business days after receipt of the Contractor's Marketing Material, shall be deemed to constitute approval of said Marketing Material. Further, EOHHS's failure to take any of the actions described in **Section 3.5.B.1** or **Section 3.5.B.2** above within ten (10) business days after notification of the Contractor in accordance with **Section 3.5.B.3**, shall be deemed to constitute approval of the Marketing Material, as shall EOHHS's failure to respond within ten (10) business days of receipt of modifications to Marketing Materials submitted to EOHHS pursuant to **Section 3.5.B.2** above.

Section 3.6 Additional Enrollee Groups

EOHHS may:

A. Develop and implement, in consultation with other entities such as but not limited to other Accountable Care Partnership Plans and MassHealth-contracted MCOs, necessary processes and procedures required to implement enrollment of additional Enrollee groups, as further specified by EOHHS;

B. Develop a benefit package for any such Enrollee group which to the extent practicable is consistent with ACO Covered Services for other Enrollee groups;

C. Inform the Contractor regarding demographic characteristics and utilization experience of any new Enrollee group prior to initiation of enrollment to the extent that such information is available;

D. Develop a Capitation Rate(s) for such Enrollee group(s) consistent with 42 CFR 447.361 and in consultation with the MassHealth-contracted Accountable Care Partnership Plans; and

E. Develop, in cooperation with the Contractor, an implementation strategy for providing services to Enrollees.

Section 3.7 Community Partners

A. EOHHS shall qualify Community Partners through a Qualified Vendor List (QVL) and notify the Contractor of available qualified Community Partners.

B. EOHHS shall provide the Contractor with necessary reporting required to administer the CP Program, including reports on enrollment, performance, payment, and quality, at a cadence further specified by EOHHS.

C. EOHHS shall monitor the Contractor's performance in the CP program and may engage the Contractor and its subcontracted CPs in performance management and compliance activities.

Section 3.8 Network PCP Modification Process

EOHHS shall maintain, and may update from time to time, an annual process for the Contractor to request EOHHS' approval for changes to the Contractor's list of Network PCPs, including ending affiliations with Network PCPs, adding new Network PCPs, and changing the Primary Care Sub-Capitation Tier Designation of existing Network Primary Care Practice PID/SLs Such changes shall in all cases be subject to EOHHS' approval. The Contractor shall submit requests for any such changes pursuant to EOHHS' defined process, including timelines, and the effective date of any such changes shall be as described by EOHHS' defined process.

SECTION 4. PAYMENT AND FINANCIAL PROVISIONS

Section 4.1 Accountable Care Partnership Plan Rating Categories

Subject to all required federal approvals, EOHHS shall pay the Contractor, in accordance with **Section 4**, by the designated Coverage Type, for providing ACO Covered Services to Enrollees in the following Rating Categories (RCs): RC I Child, RC I Adult, RC II Child, RC II Adult, RC IX (Adults only), and RC X (Adults only). Enrollees are eligible for ACO and Non-ACO Covered Services described in **Appendix C**, as appropriate, depending upon such Enrollee's Coverage Type.

A. RC I Child

RC I Child includes Enrollees who are non-disabled, under the age of 21, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505.

B. RC I Adult

RC I Adult includes enrollees who are non-disabled, age 21 to 64, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505.

C. RC II Child

RC II Child includes Enrollees who are disabled, under the age of 21, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

D. RC II Adult

RC II Adult includes Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

E. RC IX

RC IX includes Enrollees who are age 21 to 64, and in CarePlus as described in 130 CMR 505 who are not receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. RC IX shall also include Enrollees who have identified themselves to MassHealth as medically frail in accordance with 130 CMR 505.008(F), and therefore are in the MassHealth Standard coverage type.

F. RC X

RC X includes Enrollees who are age 21 to 64, and in CarePlus as described in 130 CMR 505 who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance.

Section 4.2 Payment Methodology

A. General

EOHHS shall make payment to the Contractor for ACO Covered Services provided under this

Contract, in accordance with the payment provisions in this **Section 4** and the Base Capitation Rates and payment provisions contained in **Appendix D**.

B. Base Capitation Rates for Contract Year 1

1. In Contract Year 1 (i.e., 2023), in accordance with 42 CFR 438.4, beginning on the Contract Operational Start Date, Base Capitation Rates for each Rating Category and Region for which the Contractor provides ACO Covered Services shall be Actuarially Sound Capitation Rates.

2. These Base Capitation Rates shall be Region-specific for each of the five Regions. Regions are comprised of Service Areas. A Service Area may span across more than one Region.

3. Base Capitation Rates shall be incorporated into the Contract in **Appendix D**.

4. Base Capitation Rates shall be comprised of the Core Medical Component and the Administrative Component.

   a. The Core Medical Component shall reflect the applicable costs related to the ACO covered services, in accordance with the provisions of this Contract; with the exception of the ABA add-on as described in **Section 4.5.E**, High-Cost Drug add-on as described in **Section 4.5.F**, and the SUD Services add-on as described in **Section 4.5.G**. Such component shall include the PCP Sub-Capitation Included Services as defined in **Section 1**.

   b. The Administrative Component of the Base Capitation Rate shall reflect the applicable cost of Administrative Services, underwriting gain, payer surcharge, care management, the Community Partners Program, and any other non-medical costs not otherwise paid for under the Contract, including but not limited to administering the Flexible Services program and activities related to advancing Health Equity.

5. EOHHS intends that the Base Capitation Rates shall be consistent for all Accountable Care Partnership Plans; provided, however, that EOHHS may provide a different Base Capitation Rate to an Accountable Care Partnership Plan, in EOHHS's discretion, to account for unique circumstances.

C. Base Capitation Rates for Subsequent Contract Years

1. After the first Contract Year, EOHHS shall annually develop the Base Capitation Rates for each Rating Category in each Region as described in **Section 4.2.B** above.

2. EOHHS shall meet with the Contractor annually, upon request, to announce and explain the Base Capitation Rates, including the Core Medical Component and Administrative Component of the Base Capitation Rates.

3. Prior to the beginning of the Contract Year, EOHHS shall incorporate, by amendment,

the Base Capitation Rates by RC and Region into the Contract at **Appendix D, Exhibit 1.**

4. Prior to the beginning of the Contract Year, the Contractor shall accept the Base Capitation Rates for the new Contract Year as follows:

   a. In writing, in a form and format specified by EOHHS, by a deadline specified by EOHHS that allows sufficient time for EOHHS to load such Base Capitation Rates into EOHHS's payment system.

   b. Prior to the beginning of the Contract Year, by executing an amendment to the Contract incorporating the new Base Capitation Rates, as described above.

5. EOHHS may amend the Base Capitation Rates at such other times as may be necessary as determined by EOHHS, or as a result of changes in federal or state law, including but not limited to, to account for changes in eligibility, ACO Covered Services, or copayments.

D. Failure to Accept Base Capitation Rates

1. In the event that the Contractor fails to execute an amendment to the Contract incorporating the new Base Capitation Rates for the new Contract Year as described in **Section 4.2.C** above, EOHHS will, starting January 1, pay the Contractor in accordance with **Section 4.2.E** using the new Contract Year's Risk Adjusted Capitation Rates less 1.5%. The Contractor shall accept such payment as payment in full under the Contract. EOHHS shall pay in such manner until either the Contractor accepts the new Contract Year's Base Capitation Rates in accordance with **Section 4.2.C.4** above or until EOHHS terminates the Contract.

2. In the event that the Contractor does not accept in writing the Base Capitation Rates for the new Contract Year as described in **Section 4.2.C** above, EOHHS may halt all new Enrollee assignments to the Contractor's Plan until the Contractor accepts the Base Capitation Rates offered by EOHHS.

3. In the event that the Contractor does not execute the amendment incorporating the new Base Capitation Rates for the new Contract Year within 60 days following the end of the prior Contract Year, EOHHS may terminate the Contract.

4. EOHHS will provide the Contractor notice of contract termination, and the Contract shall be terminated on a date determined by EOHHS.

5. The Contractor shall continue to provide ACO Covered Services to Enrollees until such time as all Enrollees are disenrolled from the Contractor's Plan as described in **Section 5.6.H**.

6. For any period of time where the Contractor is providing ACO Covered Services pursuant to Continued Obligations under **Section 5.6.H**, EOHHS shall pay Estimated Capitation Payments in accordance with **Section 4.2**.

7. If the Contractor does not execute an amendment to incorporate the new Base

Capitation Rates by the end of the prior Contract Year in accordance with **Section 4.2.C.4**, as described above, EOHHS may require the Contractor to pay any lost Federal Financial Participation or other lost federal funding to EOHHS, as further specified by EOHHS.

E. Risk Adjusted Capitation Rates

EOHHS intends to risk adjust the Core Medical Component of the Base Capitation Rates beginning on the Contract Operational Start Date, and when performing risk sharing calculations as described in **Section 4.5**, to reflect the different health status (also referred to as acuity) of Enrollees enrolled in the Contractor's Plan. EOHHS shall use a statistical methodology to calculate diagnosis-based risk-adjusters using a generally accepted diagnosis grouper. Such risk adjustment shall be based on an aggregation of the individual risk scores of Enrollees enrolled in the Contractor's Plan. EOHHS intends to risk adjust the Core Medical Component of the Base Capitation Rates at least annually. EOHHS may similarly risk adjust the Administrative Component of the Base Capitation Rate. The Risk Adjusted Capitation Rate shall equal the sum of the Core Medical Component of the Base Capitation Rate and the Administrative Component of the Base Capitation Rate after risk adjustment has been applied as determined by EOHHS, and any add-ons set forth in **Appendix D.** The Contractor shall accept as payment in full such Risk Adjusted Capitation Rates.

F. Estimated Capitation Payment Process

1. EOHHS shall make Estimated Capitation Payments for Enrollees in each Rating Category (RC) and Region as follows:

    a. For each RC and Region, EOHHS shall calculate an estimated full month Estimated Capitation Payment on or about the third Friday of the month preceding the Payment Month based on estimated enrollment data for the Payment Month.

    b. For Enrollees for whom EOHHS has assigned a specific disenrollment date due to a qualifying event such as an Enrollee attaining age 65 within the Payment Month, EOHHS shall make a prorated Estimated Capitation Payment to the Contractor. The prorated Estimated Capitation Payment will equal:

        1) the monthly Risk Adjusted Capitation Rate multiplied by,

        2) the number of days in the Payment Month that the Enrollee is enrolled up to and including the disenrollment date of the qualifying event divided by,

        3) the total number of days in the Payment Month.

2. The Contractor shall be responsible for providing ACO Covered Services to such Enrollees as of the Effective Date of Enrollment in accordance with **Section 2.4.B.**

G. Coverage of Newborns

EOHHS shall prospectively pay a Risk Adjusted Capitation Rate for the newborn as of the newborn's Effective Date of Enrollment.

H. Non-Medical Programs and Services

Non-Medical Programs and Services, as defined in **Section 1** of this Contract, shall not be recorded as medical service costs or administrative costs.

I. Indian Enrollees and Indian Health Care Providers

1. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. See also 42 CFR 438.14

2. The Contractor shall offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain ACO 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

3. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to ACO Covered Services for Indian Enrollees;

4. The Contractor shall pay both network and non-network Indian Health Care Providers who provide ACO 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 ACO Covered Service provided by a non-Indian Health Care Provider or the MassHealth fee for service rate for the same service, whichever is greater;

5. The Contractor shall make prompt payment to Indian Health Care Providers; and

6. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 CFR 438.14(c)(1).

J. Suspension of Payments

EOHHS may suspend payments to the Contractor in accordance with 42 CFR 455.23, et seq. and 130 CMR 450, et seq. as determined necessary or appropriate by EOHHS.

K. Non-Payment and Reporting of Provider Preventable Conditions

Pursuant to 42 CFR 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance with all provisions related to Provider Preventable Conditions, including but not limited to **Section 2.8.D.8.b** of the Contract.

L. Loss of Program Authority

As required by CMS, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitations to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Section 4.3 Adjustments or Additions to Payments

A. Other ACO-directed Incentive Programs

1. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of Provider payments tied to any other ACO-directed value-based incentive programs described in **Section 2.9.O** for the applicable time period.

2. For the Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.9.O**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

B. Stop-loss Payment

EOHHS shall pay the Contractor a stop-loss payment as follows and as further specified by EOHHS:

1. The stop-loss payment shall be an amount equal to 95 percent (95%) of allowed expenditures in excess of an attachment point per Enrollee hospital inpatient admission as determined by EOHHS and set forth in **Appendix D.**

2. EOHHS shall pay the Contractor such amount as set forth above for each loss on an interim schedule as determined by EOHHS.

3. If EOHHS determines that a payment by the Contractor for an inpatient hospital admission does not comply with **Section 2.8.D.6**, EOHHS may decrease a stop-loss payment made to the Contractor in accordance with **Section 5.4.C**

C. In-state Acute Hospital Rate Add-on/Increase Pursuant to **Section 2.8.D.6.d**

1. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of provider payments described in **Section 2.8.D.6.d** for the applicable time period.

2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.8.D.6.d**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. As directed by EOHHS, the Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4**.

D. Integrated Care Incentive Payment Pursuant to **Section 2.9.L**

1. At a frequency to be specified by EOHHS, EOHHS shall pay Contractor an amount equal to the sum of provider payments described in **Section 2.9.L.3** for the applicable time period.

2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in **Section 2.9.L.3**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

E. Clinical Quality Incentive for Acute Hospitals Pursuant to **Section 2.9.M**

1. At a frequency to be specified by EOHHS, EOHHS shall pay Contractor an amount equal to the sum of provider payments described in **Section 2.9.M.2** for the applicable time period.

2. For the performance period specified in **Section 2.9.M**, EOHHS shall perform a reconciliation after the end of the performance period to correct the amount of any payments described in **Section 2.9.M.2**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

F. Performance Improvement Initiative for Professional Services

1. At a frequency to be specified by EOHHS, EOHHS shall pay Contractor an amount equal to the sum of provider payments described in **Section 2.9.N.3** for the applicable time period.

2. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of any payments described in. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

Section 4.4 Payment Reconciliation Process

A. Enrollment-related Reconciliations

1. EOHHS shall perform the following monthly reconciliations with a lookback period determined by EOHHS and adjust Estimated Capitation Payments as below:

    a. Enrollees Who Change Rating Categories During the Payment Months included in the lookback period

    EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total Estimated Capitation Payment issued to the Contractor for Enrollees who change Rating Categories during any of the Payment Months in the lookback period, and issue a pro-rated monthly capitation payment that reflects the actual number of Enrollee Days in any of the months in the lookback period for each of the affected Rating Categories.

    b. Enrollees Who Disenroll During the Payment Month

    EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total Estimated Capitation Payment issued to the Contractor for Enrollees who disenroll from the Contractor's Plan during any of the Payment Months in the lookback period, and issue a pro-rated monthly capitation payment to reflect the actual number of Enrollee Days in any of the months in the lookback period.

    c. Members Who Enroll During a Payment Month

    For Members who enroll in the Contractor's Plan during the Payment Months in the lookback period but after the Estimated Capitation Payment has been issued to the Contractor for any of such Payment Months in the lookback period, EOHHS shall, in the month following the Payment Month, issue a pro-rated monthly capitation payment to reflect the actual number of Enrollee Days with respect to such Members for any of the payment months in the lookback period.

2. EOHHS shall perform an annual reconciliation of the Estimated Capitation Payments to adjust for any enrollment discrepancies not included in the monthly reconciliations with the lookback period determined by EOHHS;

3. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies pursuant to the reconciliations in this **Section**. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. The Contractor shall report any such overpayments to EOHHS within 60 calendar days of when the Contractor identifies the overpayment. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments as described in **Section 4**.

a. Overpayments - Overpayments shall constitute the amount actually paid to the Contractor for all Rating Categories in excess of the amount that should have been paid in accordance with EOHHS's reconciliation.

b. Underpayments – Underpayments shall constitute the amount not paid to the Contractor for all Rating Categories that should have been paid in accordance with EOHHS's reconciliation.

B. Family Planning Services Reconciliation Process

EOHHS shall perform an annual family planning services reconciliation as follows. EOHHS shall:

1. Calculate all MassHealth fee-for-service (FFS) claims paid by EOHHS for family planning services, including family planning pharmacy services, provided to Enrollees in all RCs between the first and last day of each Contract Year; and

2. Deduct the amount of such claims paid from a future Estimated Capitation Payment, or from a payment related to a reconciliation, to the Contractor after written notification to the Contractor of the amount and timing of such deduction.

C. Continuing Services Reconciliation

Provided that the Contractor submits to EOHHS by March 31st, following the end of the Contract Year, all data regarding such services as required in **Section 4.4.C.4** below, EOHHS shall perform an annual Continuing Services reconciliation as follows:

1. The Contractor shall process and pay its Providers' claims for all Continuing Services at the Contractor's contracted rate with its Providers.

2. EOHHS shall perform a reconciliation by June 30th, following the end of the Contract Year, to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by the BOH and which were provided following the conclusion of the Final Internal Appeal Decision ("approved Continuing Service claims").

3. EOHHS shall pay the Contractor no later than 12 months following the end of the Contract Year being reconciled, the total value of the approved Continuing Service claims referenced in **Section 4.4.C.2**. above, that were provided within the applicable Contract Year, provided the Contractor timely submitted all data required by EOHHS pursuant to this **Section 4.4**.

4. Approved Continuing Service claims shall include, at a minimum, the following information:

a. Enrollee information by MassHealth identification number, including date of birth, sex, dates of enrollment, the date on which the Continuing Services were provided, and current enrollment status;

b. Costs incurred, by MassHealth identification number, including date of service; and

c. Such other information as may be required pursuant to any EOHHS request for information.

5. The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Enrollee by the Contractor. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed by EOHHS. If an audit is not conducted, EOHHS shall reimburse the Contractor as otherwise provided in this **Section 4.4.**

Section 4.5 Risk Sharing Arrangements

A. General Requirement

The Contractor shall participate in any risk-sharing arrangement as directed by EOHHS in each Contract Year.

B. General Provisions

1. Each risk sharing arrangement set forth in this **Section 4.5** shall be calculated separate from any other risk sharing arrangement in this **Section 4.5**. In performing calculations for any one risk-sharing arrangement set forth in this **Section 4.5**, EOHHS shall not include the Contractor's expenditures or EOHHS' payment to the Contractor for services applicable to any other risk-sharing arrangement.

2. The arrangement described in this Section may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor. Such payments may be accounted for in future capitation payments from EOHHS to the Contractor.

3. The Contractor shall submit the following data to assist EOHHS in calculating applicable medical expenditures for the risk sharing arrangements in this section,

a. Encounter Data, as specified in this Contract;

b. Reports submitted by the Contractor applicable to the risk sharing arrangement, including any Claims run-out specified by EOHHS, including but not limited to those set forth in **Appendix A;**

4. As further specified below, all payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS. The Contractor shall work with EOHHS, and submit any additional documentation as requested by EOHHS, to resolve any discrepancies in any calculations. After good faith efforts to resolve any discrepancies in any calculation with the Contractor, EOHHS shall make the final determination of any payment or calculation of such payment.

5. The Contractor shall submit all required data and documentation described in this

Section 4.5.B by the deadline specified by EOHHS. EOHHS shall give prior written notice of such deadline. In the event the Contractor does not meet the deadline specified by EOHHS for such data and documentation, EOHHS may, in its sole discretion, either choose to not incorporate such data and documentation into the risk sharing arrangement calculations set forth in **Section 4.5** for that particular Contract Year or may choose to incorporate such data and documentation but may impose the Capitation Payment deduction as set forth in **Section 5.4.D**.

6. EOHHS may verify any data the Contractor submits to EOHHS in a manner it determines appropriate.

C. Market-Wide Risk Sharing Arrangement ("Market Corridor") for the Contract Year

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for the Core Medical Component of the Base Capitation Rate set forth in **Section 4.2** in accordance with the following provisions.

1. Overall Approach

As further described in this section, this risk sharing arrangement shall be based on certain revenue and expenditures across MassHealth managed care plans, described as Market Corridor revenue and Market Corridor expenditures, respectively.

2. Market Corridor Revenue

EOHHS shall first determine the Market Corridor revenue. For each MassHealth Accountable Care Partnership Plan ("ACPP"), Managed Care Organization ("MCO"), Primary Care Accountable Care Organization ("PCACO"), and the Primary Care Clinician Plan ("PCC Plan") (each a "plan"), EOHHS shall multiply by Region and Rating Category each plan's respective Core Medical component of the Base Capitation Rate or TCOC Benchmark, as applicable, for the Contract Year, per member, per month, by each plan's experienced member months for the Contract Year as determined by EOHHS, and by each plan's concurrent risk scores. The sum of such calculation across plans, shall equal the Market Corridor revenue.

3. Market Corridor Expenditures

EOHHS shall then determine the Market Corridor expenditures. Such expenditures shall equal the sum across plans of Core Medical actual medical expenditures related to ACO Covered Services in **Appendix C**, as well as MCO covered services (for MCOs), services included in TCOC (for PCACOs), and comparable services for the PCC Plan for the applicable Contract Year in aggregate across all Regions and Rating Categories, as applicable, and based on data provided by ACPPs and MCOs, including by the Contractor in accordance with **Section 4.5.B**, and EOHHS data for PCACOs and the PCC Plan.

a. Such expenditures shall exclude expenditures for which EOHHS makes a payment to the Contractor pursuant to stop-loss provisions at **Section 4.3.B.**

b. EOHHS may make appropriate adjustments as necessary, including, but not limited to, ACPP, MCO, PCACO, and PCC Plan specific adjustments, related to the Market Corridor expenditure calculation described above.

4. If the Market Corridor expenditures, as determined by EOHHS in accordance with the above provisions, are less than the Market Corridor revenue, as determined by EOHHS in accordance with the above provisions, each ACPP, MCO, and PCACO and EOHHS shall share the resulting gain. The Contractor shall share in the resulting gain in accordance with **Appendix D**. The Contractor's share of the Market Share of the Gain shall be directly proportional to the Contractor's share of the Market Corridor Revenue.

5. If the Market Corridor expenditures, as determined by EOHHS in accordance with the above provisions, are greater than the Market Corridor revenue, as determined by EOHHS in accordance with the above provisions, each ACPP, MCO, and PCACO and EOHHS shall share the resulting loss. The Contractor shall share in the resulting loss or in accordance with **Appendix D**. The Contractor's share of the Market Share of the Loss shall be directly proportional to the Contractor's share of the Market Corridor Revenue.

6. In addition, the Contractor's share of the resulting loss or gain, as set forth above, shall be an adjustment applied to the Contractor's Core Medical revenue for the purposes of calculating the Contract-Wide Risk Sharing Arrangement in **Section 4.5.D** below.

7. 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.

D. Contract-Wide Risk Sharing Arrangement ("Plan Corridor") for the Contract Year

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for the Core Medical Component of the Base Capitation Rate, any Market Corridor adjustment as described in **Section 4.5.C**, in accordance with the following provisions.

1. Overall Approach

As further described in this section, this risk sharing arrangement shall be based on certain revenue and expenditures for the Contractor, described as Plan Corridor revenue and Plan Corridor expenditures, respectively.

2. Plan Corridor Revenue

EOHHS shall first determine the Plan Corridor revenue. EOHHS shall multiply by Region and Rating Category the Contractor's Core Medical component of the Base Capitation Rate, for the Contract Year, as set forth in **Appendix D**, per member, per month, by the Contractor's experienced member months for the Contract Year as determined by EOHHS, and by the Contractor's concurrent risk scores. Such product, plus any Market Corridor adjustment as described in **Section 4.5.C** shall equal the Plan Corridor revenue.

3. Plan Corridor Expenditures

EOHHS shall then determine the Contractor's Plan Corridor expenditures. Such expenditures shall equal the Contractor's Core Medical actual medical expenditures in aggregate across all Regions and Rating Categories related to ACO Covered Services in **Appendix C**, for the applicable Contract Year based on data provided by the Contractor in accordance with **Section 4.5.B**.

a. Such expenditures shall exclude expenditures for which EOHHS makes a payment to the Contractor pursuant to stop-loss provisions at **Section 4.3.B**.

b. EOHHS may make appropriate adjustments as necessary related to the Plan Corridor expenditure calculation described above.

4. If the Contractor's Plan Corridor expenditures, as determined by EOHHS in accordance with the above provisions are greater than the Contractor's Plan Corridor revenue, the Contractor and EOHHS shall share the resulting loss or gain in accordance with **Appendix D**, subject to the adjustments in **Section 4.5** below.

5. If the Contractor incurs a loss that would require EOHHS to make a risk sharing payment to the Contractor, for the purposes of calculating the risk sharing payment described in this section:

a. If the Contractor has paid an amount for ACO Covered Services that exceeds the amount that EOHHS would have paid for the same services in accordance with EOHHS's fee schedule, then EOHHS may reprice the Contractor's paid Claims to reflect EOHHS's fee schedule; or

b. If the Contractor has an approved an Alternative Payment Methodology (APM) for the purposes of Base Capitation Rate development ("approved APM"), EOHHS shall apply an adjustment to the Contractor's repriced paid Claims. Such adjustment shall be determined by an attestation the Contractor submits to EOHHS in a form and format specified by EOHHS and comparable to the lesser of the approved APM adjustment applied during Base Capitation Rate development or adjustment based on approved APM expenditures in excess of EOHHS's fee schedule accrued during the Contract Year as attested to by the Contractor in a form and format specified by EOHHS. The Contractor must further attest that the APM active during the Contract Year ("active APM") is materially similar to the approved APM. Material similarity may include but is not limited to the following criteria: the active APM is paid to the same provider group(s), the active APM addresses the same service(s), and the active APM uses comparable payment methodology. EOHHS reserves the right to determine if an active APM is materially similar to an approved APM. If the Contractor does not complete an attestation, EOHHS shall not apply any adjustment to the Contractor's repriced paid claims.

c. If such the repricing described in **Section 4.5.D.5.a** or the adjustment described in **Section 4.5.D.5.b** result in the Contractor incurring a gain, EOHHS shall cap the EOHHS share of such gain at $0.

6. EOHHS shall exclude from all calculations related to this risk sharing arrangement the Contractor's reinsurance premiums paid and recovery revenues received if the Contractor chooses to purchase reinsurance.

E. ABA Services Risk Sharing Arrangement

For RCs I Child and II Child, and for Enrollees in other RCs as determined appropriate by EOHHS, the Contractor and EOHHS shall share risk for Applied Behavioral Analysis (ABA Services) in accordance with the following provisions:

1. Overall Approach

All payments shall be calculated and determined by EOHHS based on the adjusted expenditures for ABA Services and the ABA Add-On to the Risk Adjusted Capitation Rates.

2. EOHHS will first determine the amount paid to the Contractor by EOHHS for ABA Services for the Contract Year by multiplying the following:

a. The ABA Add-On to the applicable Risk Adjusted Capitation Rates, which shall be determined by EOHHS and provided to the Contactor in **Appendix D, Exhibit 1**; by

b. The number of Member months determined by EOHHS by using the Enrollee Days determined by the reconciliation set forth in **Section 4.4**.

3. EOHHS will then determine the Contractor's adjusted expenditures for ABA Services for the Contract Year by multiplying the following:

a. The number of service units provided by the Contractor with respect to ABA Services, as set forth in 101 CMR 358.03, which shall be determined by the claims data submitted in the report described in **Section 4.5.B** and by Encounter Data submitted by the Contractor;

b. The applicable rate for the ABA Services established by EOHHS in accordance with **Section 2.8.D.7.f**.

4. If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.E.2** above, is greater than or less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.E.2** above, then the Contractor shall be considered to have experienced a gain or loss with respect to ABA Services for the Contract Year. EOHHS and the Contractor shall share such gain or loss in accordance with **Appendix D, Exhibit 3**.

F. High-Cost Drug (HCD) Risk Sharing Arrangement

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for HCD, as defined in **Section 1**, in accordance with the following provisions:

1. Overall Approach

   All payments shall be calculated and determined by EOHHS based on the Contractor's actual HCD expenditures relating to all Enrollees and the HCD Add-On to the Risk Adjusted Capitation Rates.

2. EOHHS shall first determine the amount paid to the Contractor by EOHHS for HCD Add-On to the Risk Adjusted Capitation Rates by multiplying the following:

   a. The HCD Add-On to the applicable Risk Adjusted Capitation Rates, which shall be determined by EOHHS and provided to the Contractor in **Appendix D, Exhibit 1**; by

   b. The number of Member months determined by EOHHS using the Enrollee Days determined through reconciliation set forth in **Section 4.4**.

3. EOHHS will then determine the Contractor's actual medical expenditures for HCD in aggregate across all Regions and Rating Categories for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.B** above, and may verify such data in a manner it determines appropriate.

   If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.F.2** above, is greater than or less than the Contractor's actual medical expenditures, as determined by the calculation described in **Section 4.5.F.3** above, then the Contractor shall be considered to have experienced a gain or loss respectively, with respect to HCD for the Contract Year, and EOHHS and the Contractor shall share such gain or loss, respectively, in accordance with **Appendix D**, **Exhibit 3**.

G. SUD Services Risk Sharing Arrangement

For all Regions and Rating Categories, the Contractor and EOHHS shall share risk for SUD Services in accordance with the following provisions:

1. Overall Approach

   All payments shall be calculated and determined by EOHHS based on the Contractor's actual SUD Services expenditures relating to all Enrollees and the SUD Services Add-On to the Risk Adjusted Capitation Rates.

2. EOHHS will first determine the amount paid to the Contractor by EOHHS for SUD Services for the Contract Year by multiplying the following:

   a. The SUD Services Add-On to the applicable Risk Adjusted Capitation Rates, which shall be determined by EOHHS and provided to the Contactor in

Appendix D, Exhibit 1; by

b. The number of Member months determined by EOHHS using the Enrollee Days determined through the reconciliation set forth in **Section 4.4.**

3. EOHHS will then determine the Contractor's actual medical expenditures for SUD Services in aggregate across all Regions and Rating Categories for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.B** above, and may verify such data in a manner it determines appropriate.

If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.G.2** above, is greater than or less than the Contractor's actual medical expenditures, as determined by the calculation described in **Section 4.5.G.3** above, then the Contractor shall be considered to have experienced a gain or loss, respectively, with respect to SUD Services for the Contract Year, and EOHHS and the Contractor shall share such gain or loss, respectively, in accordance with **Appendix D, Exhibit 3**.

Section 4.6 Performance Incentive Arrangements and Withhold

A. Performance Incentive Arrangements

1. EOHHS may establish annual performance standards and incentive arrangements for the Contractor related to its performance of Contractor responsibilities. EOHHS shall determine whether the Contractor has met any and all such performance standards and shall provide the Contractor with written notice of such determinations.

2. In no case shall total performance incentive arrangement payments to the Contractor exceed 105% of the Contractor-specific Capitation payments, as determined by EOHHS.

3. All Performance Incentive arrangements shall meet the following requirements:

a. Performance Incentives shall be for a fixed period of time, which shall be described in the specific Performance Incentive;

b. No Performance Incentive shall be renewed automatically;

c. All Performance Incentives shall be made available to both public and private Contractors;

d. No Performance Incentive shall be conditioned on intergovernmental transfer agreements;

e. All Performance Incentives shall be necessary for the specified activities, targets, and performance measures or quality-based outcomes that support program initiatives as specified by the state's quality strategy under 42 CFR 438.340; and

f. The Contractor's performance under any Performance Incentive shall be measured for the Contract Year in which the Performance Incentive is effective.

EOHHS will perform all calculations after the conclusion of the Contract Year.

B. Quality Incentive Arrangement

1. EOHHS shall pay the Contractor a payment based on the Contractor's Quality Score described in as set forth in **Appendix Q**. Such payment shall equal no more than two percent of the Contractor's Estimated Capitation Payments as described in **Section 4** for the Contract Year.

2. The Contractor shall make all appropriate efforts to meet a set of performance targets for individual Quality Measures as set forth in **Appendix Q**.

3. EOHHS shall calculate, annually, the Contractor's Quality Score based on the Contractor's performance with respect to the Quality Measures set forth in **Appendix Q**.

    a. Such score shall be based on the Contractor's meeting or improvement towards meeting the targets and a statewide performance metric, as further specified by EOHHS and as set forth in **Appendix Q.**

    b. Such score shall be a number between zero (0) and one (1).

4. For such calculations described above, EOHHS shall use data reported by the Contractor, or other data as further specified by EOHHS.

5. Based on the Contractor's performance, EOHHS shall pay the Contractor in accordance with **Section 4.6.A**.

C. Health Equity Incentive Arrangement

EOHHS shall pay the Contractor a payment based on the Contractor's Health Equity Score described in **Section 4.6.C.2.a** and as further set forth in **Appendix Q**. Such payment shall equal no more than two percent of the capitation payment EOHHS made to the Contractor as described in **Section 4** for the Contract Year.

1. The Contractor shall make all appropriate efforts to meet a set of performance targets for individual Health Equity measures as set forth in **Appendix Q**.

2. EOHHS shall calculate, annually, the Contractor's Health Equity Score based on the Contractor's performance with respect to the Health Equity measures set forth in **Appendix Q**.

    a. Such score shall be based on the Contractor's meeting or improvement towards meeting the targets and a statewide performance metric, as further specified by EOHHS and as set forth in **Appendix Q** and shall account for:

        1) Collection of complete and accurate self-reported social risk factor data for its Enrollees, which may include race, ethnicity, language, disability status, sexual orientation, and gender identity;

2) Identification and monitoring of health care inequities through stratified reporting of performance metrics as further specified by EOHHS; and

3) Reduction of identified disparities through targeted and evidence-based interventions as demonstrated through performance metrics as further specified by EOHHS.

b. Such score shall be a number between zero (0) and one (1).

3. For such calculations described above, EOHHS shall use data reported by the Contractor, or other data further specified by EOHHS.

4. Based on the Contractor's performance, EOHHS shall pay the Contractor in accordance with **Section 4.6.A**.

D. Pharmacy Utilization Target Incentive

If, as further described in **Section 2.7.B**., the Contractor is above 101.5% of the MassHealth fee-for-service (FFS) utilization for the Contract Year, and corresponding rebate amounts, normalized and as further specified by EOHHS, EOHHS shall pay an incentive payment to the Contractor as follows:

1. EOHHS may perform such calculation by therapeutic class and then determine, in the aggregate, across all utilization, whether the Contractor is above 101.5% of the MassHealth FFS actual utilization for the Contract Year. EOHHS shall provide the Contractor with a report showing such calculation at the aggregate level.

2. The amount of the incentive payment under this section shall be in the amount of additional rebates EOHHS collects as a result of the Contractor's utilization.

E. Finders' Fee Performance Incentive

If, as further described in **Section 2.3.D**.**5**, 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.

F. Performance Incentive Withhold

1. Each month EOHHS may withhold a percentage of the Contractor's Estimated Capitation Payment for Performance Incentives.

2. All Performance Incentive withholds shall meet the following requirements:

a. Performance Incentive withholds shall be for a fixed period of time, which shall

be described in the specific Performance Incentive;

b. No Performance Incentive withhold shall be renewed automatically;

c. All Performance Incentive withholds shall be made available to both public and private Contractors;

d. No Performance Incentive withhold shall be conditioned on intergovernmental transfer agreements;

e. All Performance Incentives withholds shall be necessary for the specified activities, targets, and performance measures or quality-based outcomes that support program initiatives as specified by the state's quality strategy under 42 CFR 438.340; and

f. The Contractor's performance under any Performance Incentive withhold shall be measured during the Contract Year in which the Performance Incentive withhold is effective.

Section 4.7 Flexible Services Allocation

As described in **Section 2.23.B**, the Contract will receive a separate payment for the Flexible Services as set forth in **Appendix M.**

Section 4.8 Reinsurance

The Contractor may purchase reinsurance from a company authorized to do business in Massachusetts, to cover medical costs that exceed a threshold per Enrollee for all rating categories for the duration of the Contract period. Such reinsurance policy is not required and is at the Contractor's discretion.

Section 4.9 Option to Audit

EOHHS, or its authorized agent, may perform an audit to verify any claims data submitted by the Contractor. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed or that EOHHS shall recover from the Contractor. If an audit is not conducted, EOHHS shall, within a reasonable time after receipt of claims data from the Contractor and in accordance with any applicable timeframe described in the Contract, reimburse to the Contractor or recover from the Contractor as provided in the reconciliation processes described in this **Section 4** or the process described in accordance **Section 5.4**, as appropriate.

SECTION 5. ADDITIONAL TERMS AND CONDITIONS

Section 5.1 Administration

A. Notification of Administrative Changes

The Contractor shall notify EOHHS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor shall notify EOHHS in writing no later than 60 days prior to any material change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a Material Subcontractor. The Contractor shall notify EOHHS in writing, of all other changes no later than five business days prior to the effective date of such change. The Contractor shall notify EOHHS in writing no later than 90 days prior to the effective date of any material administrative and operational change with respect to the Contractor, including but not limited to a change to the Contractor's corporate structure, ownership, or tax identification number.

B. Assignment or Transfer

The Contractor shall not assign or transfer any right or interest in this Contract to any successor entity or other entity, including any entity that results from a merger of the Contractor and another entity, without the prior written consent of EOHHS. The Contractor shall include in such request for approval a detailed plan for EOHHS to review. The purpose of the plan review is to ensure uninterrupted services to Enrollees, evaluate the new entity's ability to support the Provider Network, ensure that services to Enrollees are not diminished and that major components of the organization and EOHHS programs are not adversely affected by the assignment or transfer of this Contract.

C. Independent Contractors

The Contractor, its employees, subcontractors, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of EOHHS or the Commonwealth of Massachusetts.

D. Subrogation

Subject to EOHHS's lien and third-party recovery rights, the Contractor shall:

1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder; and

2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or their insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder, pursuant to the Benefit Coordination Plan to be implemented under the provisions of **Section 2.20.** The Contractor may ask the Enrollee:

a. To take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and to take no action prejudicing the rights and interest of the Contractor hereunder; and

b. To notify the Contractor hereunder and to authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

E. Advance Directives

The Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The Contractor shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

F. Compliance with Certification, Program Integrity and Prohibited Affiliation Requirements

As a condition of receiving payment under this Contract, the Contractor shall comply with all applicable certification, program integrity and prohibited affiliation requirements at 42 CFR 438.600 et seq., and as described in this Contract.

G. Prohibited Affiliations and Exclusion of Entities

1. In accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting, provider, subcontractor or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded from certain procurement and non-procurement activities, under federal or state law, regulation, executive order, or guidelines.. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity nor be permitted to serve as a director, officer or partner of the Contractor. The Contractor shall provide written disclosure to EOHHS of any such prohibited affiliations identified by the Contractor.

2. The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b).

H. Physician Incentive Plans

The Contractor:

1. May, in its discretion, operate a physician incentive plan only if:

a. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

b. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Enrollee; and

c. The applicable stop-loss protection, Enrollee survey, and disclosure requirements of 42 CFR Part 417 are met;

2. Shall comply, and assure its subcontractors comply, with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 417, 434 and 1003 and 42 CFR 438.3(i), 422.208 and 422.210. The Contractor shall submit all information required to be disclosed to EOHHS in the manner and format specified by EOHHS, which, subject to federal approval, shall be consistent with the format required by the Centers for Medicare and Medicaid Services for Medicare contracts;

3. Shall be liable for any and all loss of federal financial participation (FFP) incurred by the Commonwealth that results from the Contractor's or its subcontractors' failure to comply with the requirements governing physician incentive plans at 42 CFR Parts 417, 434 and 1003 and 42 CFR 438.3(i), 422.208 and 422.210; provided, however, that the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan; provided, further, that the Contractor shall not be liable if it can demonstrate, to the satisfaction of EOHHS, that it has made a good faith effort to comply with the cited requirements; and

4. Shall implement Provider Performance Incentives (or pay-for-performance), as appropriate, to promote compliance with guidelines and other QI initiatives, in accordance with the above stipulations and **Section 2.14.D**.

I. National Provider Identifier (NPI)

The Contractor shall require each Provider providing ACO Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. 1320d-2(b). The Contractor shall provide such unique identifier to EOHHS for each of its PCPs in the format and time frame established by EOHHS.

J. Provider-Enrollee Communications

1. In accordance with 42 USC 1396u-2(b)(3) and 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their 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 their 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 shall furnish information about any service the Contractor does not cover due to moral or religious grounds as follows.

a. To EOHHS:

1) With its application for a Medicaid contract; and

2) At least 60 days prior to adopting the policy during the term of the Contract.

b. To potential Enrollees, via enrollment/Marketing materials, at least 30 days prior to adopting the policy during the term of the contract.

c. To Enrollees, at least 30 days prior to adopting the policy during the term of the Contract and in the Enrollee handbook. The Contractor shall also describe in the Enrollee handbook that the Enrollee may access such services by contacting MassHealth directly and provide contact information.

3. The Contractor shall accept a reduction in the Capitation Rate for any service it does not provide, reimburse for, or provide coverage of due to moral or religious grounds.

K. No Enrollee Liability for Payment

1. The Contractor shall:

a. Ensure, in accordance with 42 USC §1396 u-2(b)(6) and 42 CFR 438.106, that an Enrollee will not be held liable:

1) For debts of the Contractor, in the event of the Contractor's insolvency;

2) For services (other than excluded services set forth in **Appendix C**) provided to the Enrollee in the event that:

a) The Contractor fails to receive payment from EOHHS for such services; or

b) A Provider fails to receive payment from EOHHS or the Contractor for such services, including but not limited to

payments that are in excess of the amount the enrollee would owe if the Contractor covered the service directly.

b. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in **Section 5.1.k.2** below.

c. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any charge permitted under **Section 5.1.k.2**.

d. Not deny any service provided under this Contract to an Enrollee who, prior to becoming MassHealth eligible, incurred a debt that has not been paid.

e. Ensure Provider compliance with all Enrollee payment restrictions, including balance billing and co-payment provisions, and develop and implement a plan to sanction any Provider that does not comply with such provisions.

f. Return to the Enrollee the amount of any liability inappropriately imposed on and paid by the Enrollee.

2. Copayments and Cost Sharing

a. Notwithstanding any other requirement in this contract, the Contractor shall charge Enrollees copayments in the same amounts and for the same services as the copayments established by EOHHS for Members. See 130 CMR 450.130, 130 CMR 506.014, and 130 CMR 520.036.

b. As further directed by EOHHS, the Contractor shall apply copayments in the manner EOHHS applies copayments for Members, including but not limited to exclusions, copayment caps, and prohibiting providers from refusing to provide a service to an Enrollee is who unable to pay at the time a service is provided. See 130 CMR 506.015-018 and 130 CMR 520.037-040.

c. As further directed by EOHHS, the Contractor shall implement federal and other cost sharing initiatives specified by EOHHS. Such implementation shall include, but may not be limited to:

1) Submitting the Inbound Co-pay Data File as specified in **Appendix J**, and resubmitting files to correct errors as required by EOHHS;

2) Receiving and processing the Daily Outbound Copay File as specified in **Appendix J**;

3) Developing a process, that does not require an Enrollee taking initial action, to address situations where an Enrollee pays over their copay limit (also referred to as member overage). The Contractor shall submit

such process to EOHHS for EOHHS approval, modify any part of the process upon receiving feedback from EOHHS, and resubmit such updated proposed process for EOHHS approval. The Contractor shall implement the final, EOHHS-approved process and report on overages as specified in **Appendix A**; and

4) Not implementing any copayments or other cost sharing on preventative services as specified by EOHHS. The Contractor shall maintain a list of preventative services consistent with EOHHS' list of preventative services and shall update such list as specified by EOHHS.

L. Enrollee Rights

1. The Contractor shall have written policies regarding Enrollee rights and shall comply with any applicable federal and state laws that pertain to Enrollee rights;

2. The Contractor shall ensure that its staff and affiliated Providers take those rights into account when furnishing services to Enrollees;

3. Enrollee rights shall include:

a. The right to receive the information required pursuant to this Contract;

b. The right to be treated with respect and with due consideration for their dignity and privacy;

c. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

d. The right to receive a second opinion on a medical procedure and have the Contractor pay for such second opinion consultation visit;

e. The right to participate in decisions regarding their care, including the right to refuse treatment;

f. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

g. The right to freely exercise their rights without adversely affecting the way the Contractor and its Providers treat the Enrollee;

h. The right to request and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526; and

i. The right to be furnished ACO Covered Services in accordance with this

Contract.

M. Coverage of Emergency, Screening and Post-Stabilization Services

The Contractor shall comply, and assure its Providers and Material Subcontractors comply with all state and federal requirements governing Emergency, Screening and Post-Stabilization services including, but not limited to, 42 USC § 1395dd, 42 USC § 1396u-2(b)(2).

N. Restraint and Seclusion

The Contractor shall require any Provider that is a psychiatric residential treatment facility providing inpatient psychiatric services to individuals under age 21, to comply with all requirements relating to restraint and seclusion as set forth in 42 CFR 441.151 subpart D, and 42 CFR 483 subpart G and in DMH's Human Rights and Restraint and Seclusion Policy, as specified in **Appendix G**.

O. Disclosure Requirements

1. The Contractor shall within one business day disclose to EOHHS any non-compliance by the Contractor with any provision of this Contract, or any state or federal law or regulation governing this Contract.

2. The Contractor shall make the following federally required disclosures in accordance with 42. CFR § 455.100, et seq. and 42 U.S.C. § 1396b(m)(4)(A) in the form and format specified by EOHHS.

   a. Ownership and control

      Upon any renewal or extension of this Contract and within 35 days of any change in ownership, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.104 regarding ownership and control, both with respect to the Contractor and Material Subcontractors. The Contractor shall complete the validation of federally required disclosure forms for their Material Subcontractors to ensure that the information is complete and providers are in good stead.

   b. Business Transactions

      Within 35 days of a written request by EOHHS, or the U.S. Department of Health and Human Services, the Contractor shall furnish full and complete information to EOHHS, or the U.S. Department of Health and Human Services, as required by 42 CFR 455.105 regarding business transactions.

   c. Criminal convictions

      Upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to

EOHHS as required by 42 CFR 455.106 regarding persons convicted of crimes.

d. Other disclosures

1) The Contractor shall comply with all reporting and disclosure requirements of 41 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act; and

2) In accordance with section 1903(m)(4)(B) of the Social Security Act, the Contractor shall make such reports regarding certain transactions with parties of interest available to Enrollees upon reasonable request;

3. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Section 5.1.O.2.a-c** above, the Contractor shall fully and accurately complete the EOHHS forms developed for such purpose as specified by EOHHS, including any EOHHS form for the disclosure and any EOHHS form required to post such disclosure on EOHHS's website in accordance with federal law, often referred to as the MassHealth Federally-Required Disclosures Form and Addendum, respectively.

4. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 5.1.O** or in response to the information contained in the Contractor's disclosures under this **Section 5.1.O**. In addition, the Contractor shall not be entitled to payment for any MassHealth services for which EOHHS determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238, et seq. to impose sanctions.

Section 5.2 Privacy and Security of Personal Data and HIPAA Compliance

A. Covered Entities

EOHHS and the Contractor acknowledge that they are covered entities, as defined at 45 CFR 160.103.

B. Contractor's Compliance with HIPAA

The Contractor represents and warrants that:

1. It shall conform to the requirements of all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations;

2. It shall work cooperatively with EOHHS on all activities related to ongoing compliance with HIPAA requirements, as directed by EOHHS; and

3. It shall execute, at EOHHS's direction, a Trading Partner Agreement and any other agreements EOHHS determines are necessary to comply with HIPAA requirements.

C. Research Data

The Contractor shall seek and obtain EOHHS prior written authorization for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

D. Requesting Member-Level Data or Reports

If the Contractor wishes to receive member-level data or reports that may be available from EOHHS under the Contract, the Contractor may be required to submit a request to EOHHS and execute a Data Use Agreement containing any representations and/or privacy and security requirements applicable to the data and/or report(s) that EOHHS may determine necessary or appropriate.

Section 5.3 General Terms and Conditions

A. Compliance with Laws

1. The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the Assisted Suicide Funding Restriction Act of 1997; Titles XIX and XXI of the Social Security Act and waivers thereof; Chapter 141 of the Acts of 2000 and applicable regulations; Chapter 58 of the Acts of 2006 and applicable regulations; 42 CFR Part 438; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations; and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, including but not limited to section 1557 of such Act, to the extent such provisions apply and other laws regarding privacy and confidentiality, and as applicable, the Clean Air Act, Federal Water Pollution Control Act, and the Byrd Anti-Lobbying Amendment and, as applicable, the CMS Interoperability and Patient Access Final Rule (CMS 9115-F).

2. In accordance with 130 CMR 450.123(B), the Contractor shall review its administrative and other practices, including the administrative and other practices of any contracted Behavioral Health organization, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance and submit a certification to EOHHS in accordance with 130 CMR 450.123(B)(1)-(3) and any additional instructions provided by EOHHS.

3. The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with

any requirement of federal law or regulation.

B. Loss of Licensure/Accreditation

If, at any time during the term of this Contract, the Contractor or any of its Providers or Material Subcontractors incurs loss of clinical licensure, accreditation or necessary state approvals, the Contractor shall report such loss to EOHHS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.6** herein.

C. Statutory Requirements

The Contractor shall comply with all applicable requirements regarding the privacy, security, use and disclosure of personal data (including protected health information, such as medical records and any other health and enrollment information), including, but not limited to, requirements set forth in M.G.L. c. 66A, 42 CFR 431, Subpart F, and 45 CFR Parts 160, 162 and 164.

D. Indemnification

The Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, or any of its subcontractors provided that:

1. The Contractor is notified of any claims within a reasonable time from when EOHHS becomes aware of the claim; and,

2. The Contractor is afforded an opportunity to participate in the defense of such claims.

E. Prohibition Against Discrimination

1. In accordance with 42 USC § 1396u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reasons for its decision. This Section shall not be construed to prohibit the Contractor from including Providers only to the extent necessary to meet the needs of the Contractor's Enrollees, or from using different reimbursement for different Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

2. If a complaint or claim against the Contractor is presented to the Massachusetts Commission Against Discrimination (MCAD), the Contractor shall cooperate with MCAD in the investigation and disposition of such complaint or claim.

3. In accordance with 42 U.S.C. § 1396u-2 and 42 CFR 438.3(d), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating

against a Member eligible to enroll in the Contractor's MassHealth Plan on the basis of health status, need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

F. Information Sharing

During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable federal and state laws, the Contractor shall arrange for the transfer, at no cost to EOHHS or the Enrollee, of medical information regarding such Enrollee to any subsequent provider of medical services to such Enrollee, as may be requested by the Enrollee or such provider or be directed by EOHHS, the Enrollee, regulatory agencies of the Commonwealth, or the United States Government. With respect to Enrollees who are children in the care or custody of the Commonwealth, the Contractor shall provide, upon reasonable request of the state agency with custody of the Enrollee, a copy of said Enrollee's medical records and any Care Management documentation in a timely manner.

G. Other Contracts

Nothing contained in this Contract shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor shall not serve as another ACO model under the MassHealth ACO program. The Contractor shall also provide EOHHS with a complete list of such plans and services, upon request. EOHHS shall exercise discretion in disclosing information which the Contractor may consider proprietary, except as required by law. Nothing in this Contract shall be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other provider.

H. Title and Intellectual Property Rights

1. Definitions

a. The term "Property" as used herein includes the following forms of property: (1) confidential, proprietary, and trade secret information; (2) trademarks, trade names, discoveries, inventions processes, methods and improvements, whether or not patentable or subject to copyright protection and whether or not reduced to tangible form or reduced to practice; and (3) works of authorship, wherein such forms of property are required by the Contractor to develop, test, and install the any product to be developed that may consist of computer programs (in object and source code form), scripts, data, documentation, text, photographs, video, pictures, sound recordings, training materials, images, techniques, methods, program images, text visible on the Internet, illustrations, graphics, pages, storyboards, writings, drawings, sketches, models, samples, data, other technical or business information, reports, and other works of authorship fixed in any tangible medium.

b. The term “Deliverable” as used herein is defined as any work product that the Contractor delivers for the purposes of fulfilling its obligations under the Contract.

2. Contractor Property and License

a. The Contractor will retain all right, title and interest in and to all Property developed by it, i) for clients other than the Commonwealth, and ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor in connection with such work (hereinafter the “Contractor Property”). EOHHS acknowledges that its possession, installation or use of Contractor Property will not transfer to it any title to such property. “Contractor Property” also includes Contractor’s proprietary tools, methodologies and materials developed prior to the performance of Services and used by Contractor in the performance of its business and specifically set forth in this Contract and which do not contain, and are not derived from, EOHHS’s Confidential Information, EOHHS’s Property or the Commonwealth Data.

b. Except as expressly authorized herein, EOHHS will not copy, modify, distribute or transfer by any means, display, sublicense, rent, reverse engineer, decompile or disassemble Contractor Property.

c. The Contractor grants to EOHHS, a fully-paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit, copy, sublicense to any EOHHS subcontractor for purposes of creating, implementing, maintaining or enhancing a Deliverable, and create derivative works based upon Contractor Property, in any media now known or hereafter known, to the extent the same are embodied in the Deliverables, or otherwise required to exploit the Deliverables. During the Contract Term and immediately upon any expiration or termination thereof for any reason, the Contractor will provide to EOHHS the most current copies of any Contractor Property to which EOHHS has rights pursuant to the foregoing, including any related Documentation.

d. Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS's use of Contractor Property under the license created herein, the Contractor shall have all the rights and incidents of ownership with respect to Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties. The Contractor shall not encumber or otherwise transfer any rights that would preclude a free and clear license grant to the Commonwealth.

3. Commonwealth Property

a. In conformance with the Commonwealth Terms and Conditions, all Deliverables created under this Contract whether made by the Contractor, subcontractor or both are the property of EOHHS, except for the Contractor Property embodied in the Deliverable. The Contractor irrevocably and unconditionally sells, transfers and assigns to EOHHS or its designee(s), the entire right, title, and interest in and to all intellectual property rights that it may now or hereafter possess in said Deliverables, except for the Contractor Property embodied in the Deliverables, and all derivative works thereof. This sale, transfer and assignment shall be effective immediately upon creation of each Deliverable and shall include all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor or subcontractor in connection with such work (hereinafter the "Commonwealth Property"). "Commonwealth Property" shall also include the specifications, instructions, designs, information, and/or materials, proprietary tools and methodologies including, but not limited to software and hardware, owned, licensed or leased by EOHHS and which is provided by EOHHS to the Contractor or of which the Contractor otherwise becomes aware as well as EOHHS's Confidential Information, the Commonwealth Data and EOHHS's intellectual property and other information relating to its internal operations.

b. All material contained within a Deliverable and created under this Contract are works made for hire.

c. The Contractor agrees to execute all documents and take all actions that may be reasonably requested by EOHHS to evidence the transfer of ownership of or license to intellectual property rights described in this **Section 5.3** including providing any code used exclusively to develop such Deliverables for EOHHS and the documentation for such code. The Commonwealth retains all right, title and interest in and to all derivative works of Commonwealth Property.

d. EOHHS hereby grants to the Contractor a nonexclusive, revocable license to use, copy, modify and prepare derivative works of Commonwealth Property only during the term and only for the purpose of performing services and developing Deliverables for the EOHHS under this Contract.

e. The Contractor agrees that it will not: (a) permit any third party to use Commonwealth Property; (b) sell, rent, license or otherwise use the Commonwealth Property for any purpose other than as expressly authorized under this Contract; or (c) allow or cause any information accessed or made available through use of the Commonwealth Property to be published, redistributed or retransmitted or used for any purpose other than as expressly authorized under this Contract. The Contractor agrees not to, modify the Commonwealth Property in any way, enhance or otherwise create derivative

works based upon the Commonwealth Property or reverse engineer, decompile or otherwise attempt to secure the source code for all or any part of the Commonwealth Property, without EOHHS's express prior consent. EOHHS reserves the right to modify or eliminate any portion of the Commonwealth Property in any way at any time. EOHHS may terminate use of the Commonwealth Property by the Contractor immediately and without prior notice in the event of the failure of such person to comply with the security or confidentiality obligations hereunder. The Commonwealth Property is provided "AS IS" and EOHHS FOR ITSELF, ITS AGENCIES AND ANY RELEVANT AUTHORIZED USERS EXPRESSLY DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES CONCERNING THE COMMONWEATH PROPERTY, COMMONWEALTH DATA OR ANY THIRD PARTY CONTENT TO BE PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, OR STATUTORY, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF NONINFRINGEMENT, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR QUALITY OF SERVICES.

I. 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.

J. Entire Contract

This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein except as otherwise provided in **Section 5.3.N**. The terms of this Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein. This Contract, including the Commonwealth of Massachusetts Standard Contract Form and Commonwealth Terms and Conditions, shall supersede any conflicting verbal or written agreements, forms, or other documents relating to the performance of this Contract.

K. No Third-Party Enforcement

No person not executing this Contract shall be entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

L. Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

M. Administrative Procedures Not Covered

EOHHS may, from time-to-time, issue memoranda clarifying, elaborating upon, explaining or

otherwise relating to Contract administration and other management matters.

N. Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void and any such invalidity shall not affect the validity of the remainder of this Contract. Moreover, the Contractor shall comply with any such applicable state or federal law or regulation.

O. Conflict of Interest

Neither the Contractor nor any Material Subcontractor shall, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual or other business interest in any entity performing health plan enrollment functions for EOHHS, the CSC Vendor and subcontractor(s) if any).

P. Insurance for Contractor's Employees

1. The Contractor shall agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and shall provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, shall obtain and maintain appropriate professional liability insurance coverage. The Contractor shall, at EOHHS's request, provide certification of professional liability insurance coverage.

2. The Contractor shall offer health insurance to its employees sufficient to ensure that it is not obligated to provide a share payment under Chapter 58.

Q. Waiver

EOHHS's exercise or non-exercise of any authority under this Contract, including, but not limited to, review and approval of materials submitted in relation to the Contract, shall not relieve the Contractor of any obligations set forth herein, nor be construed as a waiver of any of the Contractor's obligations or as acceptance by EOHHS of any unsatisfactory practices or breaches by the Contractor.

Section 5.4 Intermediate Sanctions

A. General Requirements

1. In addition to Termination under **Section 5.6**, EOHHS may, in its sole discretion, impose any or all of the sanctions in **Section 5.4.A.2** upon any of the events below; provided, however, that EOHHS shall only impose those sanctions it determines to be reasonable and appropriate for the specific violation(s) identified. Sanctions may be imposed in accordance with this Section if the Contractor:

a. Fails substantially to provide Medically Necessary items and services required to be provided under this Contract or under law to Enrollees;

b. Imposes co-payments, premiums or other charges on Enrollees in excess of any permitted under this Contract;

c. Discriminates among Enrollees on the basis of health status or need for health care services, including termination of enrollment or refusal to reenroll an Enrollee, except as permitted under **Section 2.4.D**, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services;

d. Misrepresents or falsifies information provided to CMS or EOHHS;

e. Misrepresents or falsifies information provided to Enrollees, Members, or providers;

f. Fails to comply with requirements regarding physician incentive plans;

g. Fails to comply with requirements regarding Provider-Enrollee communications;

h. Fails to comply with applicable federal or state statutory or regulatory requirements related to this Contract;

i. Violates restrictions or other requirements regarding Marketing;

j. Fails to comply with quality improvement goal requirements consistent with **Appendix B**;

k. Fails to comply with any corrective action plan required by EOHHS;

l. Fails to comply with financial solvency requirements as set forth in **Section 2.16**;

m. Fails to comply with any other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations;

n. Fails to comply with the False Claims provision of the Deficit Reduction Act of 2005;

o. Submits Contract management reports, Care Management reports, or quality improvement goal reports that are either late or missing a significant amount of information or data;

p. Fails to meet any of the standards for data submission described in this Contract, including accuracy, completeness, timeliness, and other standards for Encounter Data described in **Section 2.15** and **Appendix E**. Sanctions for such

failure are further described in **Section 5.4.D** below;

q. Fails to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as set forth in **Section 2.7.B.9.c**.; or

r. Fails to comply with any other requirements of this Contract.

2. Such sanctions may include, but are not limited to:

a. Civil money penalties in accordance with 42 CFR 438.704 and **Section 5.4.A.4** below;

b. Financial measures EOHHS determines are appropriate to address the violation;

c. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396u-2(e)(2)(B) and 42 CFR 438.706;

d. Notifying the affected Enrollees of their right to disenroll;

e. Suspension of enrollment (including assignment of Enrollees);

f. Suspension of payment to the Contractor for Enrollees enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

g. Disenrollment of Enrollees;

h. Limitation of the Contractor's coverage area;

i. Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance; and

j. Such other measures as EOHHS determines appropriate to address the violation.

3. Civil money penalties shall be administered in accordance with 42 CFR 438.704 as follows:

a. The limit is $25,000 for each determination under the following subsections of **Section 5.4.A.1** above:

1) **a** (failure to provide Medically Necessary items and services);

2) **e** (misrepresentation or false statement to an Enrollee, Member, or provider);

3) **f** (failure to comply with requirements regarding physician incentive

plans); or

4) **i** (violates restrictions or other requirements regarding Marketing).

b. The limit is $100,000 for each determination under the following subsections of **Section 5.4.A.1** above:

1) **c** (discrimination); or

2) **d** (misrepresentation or false statements to CMS or EOHHS).

c. The limit is $15,000 for each Enrollee EOHHS determines was terminated or not re-enrolled because of a discriminatory practice under **Section 5.4.A.1.c** above (with an overall limit of $100,000 under **Section 5.4.A.4.b** above).

d. The limit is $25,000 or double the amount of the excess charges, whichever is greater, for each determination under **Section 5.A.4.1.b** above.

4. The intermediate sanctions provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

5. Before imposing any of the intermediate sanctions specified in this **Section 5.4**, EOHHS shall give the Contractor written notice that explains the basis and nature of the sanctions not less than 14 calendar days before imposing such sanction.

6. For any Contractor responsibilities for which the Contractor utilizes a Material Subcontractor, if EOHHS identifies any deficiency in the Contractor's performance under the Contract for which the Contractor has not successfully implemented an approved corrective action plan in accordance with **Section 5.4**, EOHHS may:

a. Require the Contractor to modify or terminate its subcontract with its existing Material Subcontractor and, if so terminating, subcontract with a different Material Subcontractor deemed satisfactory by EOHHS; or

b. Otherwise require the Contractor to alter the manner or method in which the Contractor performs such Contractor responsibility.

B. Denial of Payment Sanction

In accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e), EOHHS shall deny payments under this Contract to the Contractor for new Enrollees if CMS denies payment to EOHHS for the same new Enrollees in the following situations:

1. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.4.A.1.a-f** of this Contract is affirmed on review pursuant to 42 CFR 438.730(d).

2. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.4.A.1.a-f** of this Contract is not timely contested by the Contractor under 42

CFR 438.730(c).

For the purposes of this **Section 5.4.B**, New Enrollee shall be defined as an Enrollee that applies for enrollment after the Effective Date of this Sanction (the date determined in accordance with 42 CFR 438.730(f)).

C. Hospital Payment Sanction

If the Contractor does not comply with **Section 2.8.D.6** with respect to its payments to hospitals, EOHHS may decrease the stop-loss payment made to the Contractor as described in **Section 4.3.B.** Such decrease shall be in an amount to bring the total stop-loss payment to be equal to as if the Contractor had complied with **Section 2.8.D.6.**

D. Encounter Data Capitation Payment Deduction

Quarterly, if EOHHS determines that the Contractor has not met the Encounter Data submission requirements as set forth in **Section 2.15.B.13** and has not satisfactorily completed a data remediation action plan in accordance with **Section 2.15.B.14**, EOHHS shall apply a Capitation Payment deduction equaling up to 1% of the Contractor's total annual capitation payment for that Contract Year. Annually, such Capitation Payment deductions shall not exceed 2% of the Contractor's total annual capitation payment.

E. Pharmacy Utilization Capitation Payment Deduction

If, as described in **Section 2.7.B.9.e.2**, the Contractor is below 98.5% of the MassHealth fee-for-service (FFS) utilization for the Contract Year, and corresponding rebate amounts, normalized and as further specified by EOHHS, EOHHS shall apply a Capitation Payment deduction as follows:

1. EOHHS may perform such calculation by therapeutic class and then determine, in the aggregate, across all utilization, whether the Contractor is below 98.5% of the MassHealth FFS actual utilization for the Contract Year. EOHHS shall provide the Contractor with a report showing such calculation at the aggregate level.

2. The amount of the Capitation Payment deduction under this section shall be in the amount of rebates lost to EOHHS for the Contract Year as a result of the Contractor's failure to meet such requirement as set forth in **Section 2.7.B.9.c**

3. Notwithstanding the deduction described in this Section, EOHHS may take corrective action for a failure by the Contractor to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as specified in this Contract, including those requirements set forth in **Section 2.7.B.9.c**

F. Overpayment Capitation Deduction

1. In accordance with **Section 2.3.D.4**, 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;

2. In accordance with **Section 2.3.D.4**, 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:

    a. 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.

    b. 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.

3. 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.F**.

4. 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 2.3.D.4.a**.

G. Flexible Services Sanction

As further specified by EOHHS, if the Contractor does not meet the requirements of **Section 2.23.B**, EOHHS may reduce the Contractor's Flexible Services payments, otherwise recoup payment from the Contractor, or limit the amount of Flexible Services funding the Contractor may roll over.

H. Corrective Action Plan

If, at any time, EOHHS reasonably determines that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. EOHHS shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall promptly and diligently implement the corrective action plan as approved by

EOHHS.

EOHHS may also initiate a corrective action plan for the Contractor to implement. The Contractor shall promptly and diligently implement any EOHHS-initiated corrective action plan. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by EOHHS or other Intermediate Sanctions as described in this **Section 5.4**.

Section 5.5 Record Retention, Inspection, and Audit

A. The Contractor shall cause the administrative and medical records maintained by the Contractor, its ACO Partner, its subcontractors, and Network Providers, as required by EOHHS and other regulatory agencies, to be made available to EOHHS and its agents, designees or contractors, any other authorized representatives of the Commonwealth of Massachusetts or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial and/or medical audits, programmatic review, inspections, and examinations, provided that such activities shall be conducted during the normal business hours of the Contractor. Such records shall be maintained and available to EOHHS for seven (7) years. Such administrative and medical records shall include but not be limited to Care Management documentation, financial statements, Provider Contracts, contracts with subcontractors, including financial provisions of such Provider Contracts and subcontractor contracts. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his designee, the Governor or his designee, and the State Auditor or his designee may inspect and audit any financial records of the Contractor or its subcontractors.

B. Notwithstanding the generality of the foregoing, pursuant to 42 CFR 438.3(h), EOHHS, other representatives from the Commonwealth of Massachusetts, CMS, the Office of the Inspector General, the Comptroller General, and their designees, may, at any time, inspect and audit any records or documents of the Contractor or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where activities or work related to this Contract is conducted. The right to audit under this Section exists for 10 years from the last day of this Contract or from the date of completion of any audit, whichever is later. The Contractor shall maintain all records and documents relating to activities or work under this Contract for a period of no less than 10 years.

C. In cases where such an audit or review results in EOHHS believing an overpayment has been made, EOHHS may seek to pursue recovery of overpayments. EOHHS will notify the Contractor in writing of the facts upon which it bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than EOHHS), EOHHS will so inform the Contractor and, in such cases, the Contractor may contest only the factual assertion that the federal or state agency made such a determination. The Contractor may not contest in any proceeding before or against EOHHS the amount or basis for such determination.

Section 5.6 Termination of Contract

A. Termination by EOHHS

1. EOHHS may terminate this Contract immediately and without prior written notice upon any of the events below. EOHHS shall provide written notice to the Contractor upon such termination.

   a. The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

   b. The Contractor's admission in writing that it is unable to pay its debts as they mature;

   c. The Contractor's assignment for the benefit of creditors;

   d. Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceedings;

   e. Commencement of an involuntary proceeding against the Contractor or subcontractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law which is not dismissed within sixty days;

   f. The Contractor incurs loss of any of the following: (1) licensure at any of the Contractor's facilities; (2) state approval of the Contractor; or (3) NCQA accreditation;

   g. The Contractor is non-compliant with **Section 5.1.G** regarding prohibited affiliations and exclusion of entities and the Secretary, as permitted under federal law, directs EOHHS to terminate, or does not permit EOHHS to extend, renew, or otherwise continue this Contract.

   h. Cessation in whole or in part of state or federal funding for this Contract, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases;

2. Termination with prior notice

   a. EOHHS may terminate this Contract upon breach by the Contractor of any duty or obligation hereunder which breach continues unremedied for 30 days after written notice thereof by EOHHS.

   b. EOHHS may terminate this Contract after written notice thereof to the Contractor in the event the Contractor fails to accept any Capitation Rate established by EOHHS.

c. EOHHS may terminate this Contract if the Contractor terminates its written contract with the Contractor's ACO Partner for any reason.

d. EOHHS may terminate this Contract immediately after written notice in the event the Contractor fails to agree to amend the Contract

e. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708 in accordance with **Section 5.6.B** of this Contract.

f. EOHHS may terminate this Contract with written notice if the ACO Program is not performing as expected as further described in **Section 5.6.E** below.

g. EOHHS may terminate this Contract with written notice if, in EOHHS' sole determination, Contractor has significant programmatic cause for exit, as described in **Section 5.6.E** below.

3. For reasons for termination set forth in this **Section 5.6.A**, except as otherwise set forth in this **Section 5.6**, including but not limited to for the reasons described in **Section 5.6.A.2.f-g** above, the Contractor and EOHHS shall mutually agree upon the date the Contract shall terminate. If not all Enrollees have been disenrolled from the Contractor's Plan at the time of Contract termination, then the Contractor shall enter Continued Obligations as described in **Section 5.6.H.**

B. Termination Pursuant to 42 CFR 438.708

1. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708

2. If EOHHS terminates this Contract pursuant to its authority under 42 CFR 438.708, EOHHS shall provide the Contractor with a pre-termination hearing in accordance with 42 CFR 438.710 as follows:

a. EOHHS shall give the Contractor written notice of intent to terminate, the reason for termination, and the time and place of the hearing;

b. After the hearing, EOHHS shall give the Contractor written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and

c. If the decision is affirmed, EOHHS shall give enrollees notice of the termination and information on their options for receiving MassHealth services following the effective date of termination in accordance with 42 CFR 438.710(b)(2)(iii) and **Section 5.6.H** Of this contract.

C. Termination by the Contractor for EOHHS Breach

The Contractor may terminate this Contract upon a material breach by EOHHS of a duty or obligation in **Section 4** of this Contract that creates significant challenges for the Contractor to

continue performing under this Contract. The Contractor and EOHHS shall mutually agree upon the date the Contract shall terminate. If not all Enrollees have been disenrolled from the Contractor's Plan at the time of Contract termination, then the Contractor shall enter Continued Obligations as described in **Section 5.6.H**.

D. Termination by the Contractor Pursuant to Contractor's Annual Option to Terminate Contract

Starting in Contract Year 2, the Contractor may terminate this Contract by providing written notice to EOHHS as further specified in this section and by EOHHS. The Contractor shall submit such notice between October 1 of the current Contract Year (i.e., October 1 of Contract Year 2 or future years) and 21 days prior to the first day of the new Contract Year (for the purposes of this section, "Closing Contract Year"). In such instances:

1. The Contractor shall work with EOHHS ensure a smooth termination of the Contract, including but not limited to transitioning Enrollees and Providers.

2. EOHHS shall amend the Contract as follows, and as further specified by EOHHS:

    a. The duration of the amended Contract shall be for 12 months, and shall terminate at 11:59 p.m. of the last day of the Closing Contract Year

    b. EOHHS shall pay the Contractor in accordance with **Section 4** and **Appendix D**;

    c. EOHHS may, at its discretion, adjust the Contract-Wide Risk Arrangement set forth in **Section 4.5.D** to mitigate risk during the Closing Contract Year;

    d. The Contractor shall, to facilitate the transition of Enrollees to another MassHealth ACO, MCO, or the PCC Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment, Enrollees in care management, Enrollees with active prior authorizations, and Enrollees' active drug prescriptions

3. The Contractor shall make good faith effort to assist their PCPs in becoming PCPs of other Accountable Care Partnerships Plans, Primary Care ACOs, and MCOs. Such efforts shall include, but not be limited to, providing appropriate and reasonable data on the provider's enrollees to facilitate conversations with other health plans.

4. If, after providing notification of intent to terminate, the Contractor for any reason does not sign an amendment to extend the Contract through the Closing Contract Year under modified terms:

    a. The Contractor shall enter into Continued Obligations as described in **Section 5.6.H**, and EOHHS shall pay the Contractor in accordance with such section

    b. EOHHS shall not pay the MassHealth Share of any Loss due to the Contractor after Risk Sharing Arrangements calculations are complete from the year the contract is terminated, and during the period of Continued Obligations

c. The Contract will terminate at 11:59 pm of the last day of the Contract Year where notification of termination is provided.

E. Termination without Penalty

1. EOHHS may terminate this Contract if EOHHS determines that the ACO Program is not performing in whole or in part in accordance with EOHHS' expectations or that state or federal health care reform initiatives or state or federal health care cost containment initiatives make termination of the Contract necessary or advisable as determined by EOHHS.

2. Programmatic cause for exit

a. EOHHS may terminate this Contract if, in EOHHS' sole determination, the Contractor has significant programmatic cause for exit, as further specified by EOHHS.

b. The Contractor may request a finding of significant programmatic cause for exit at any time by submitting a written request to EOHHS, in a form and format specified by EOHHS. The Contractor shall provide any additional information requested related to the request;

c. EOHHS may, but is not obligated to, find significant programmatic cause for exit for the following reasons:

1) Losses greater than 5% of the Risk Adjusted Capitation Payment in the last two recently completed Contract Years;

2) The Contractor or its Network PCPs have merged with another ACO in the MassHealth ACO program;

3. Termination pursuant to this section will be effective at 11:59 p.m. of the last day of the current Contract Year, unless otherwise specified by EOHHS. If not all Enrollees have been disenrolled from the Contractor's Plan at the time of Contract termination, the Contractor shall enter Continued Obligations as described in **Section 5.H**.

F. Termination with Penalty

1. In the event of Contract termination pursuant to any of the following, the Contractor shall be subject to a penalty:

a. **Section 5.6.A.1**, with the exception of **5.6.A.1.h**.

b. **Section 5.6.A.2.a-e**.

2. The penalty shall consist of the greater of either:

a. 3% of the total annual Capitation Payment EOHHS paid to the Contractor for the last fully completed Contract Year, plus 3% of Capitation Payments made during Continuing Obligations. If a full Contract Year has not been completed, the penalty shall equal 3% of estimated total annual Capitation Payment that EOHHS would have paid to the Contractor for the first Contract Year, as estimated by EOHHS; or

b. The MassHealth share of any Shared Losses for the last fully completed Contract Year, in addition to any Shared Losses accrued during Continued Obligations

3. If the Contract is terminated pursuant to **Section 5.6.F.1**, EOHHS may at its sole discretion eliminate or reduce any Quality and Health Equity Incentive Arrangement payments that the Contractor is otherwise eligible to receive.

G. Termination Authority

The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

H. Continued Obligations of the Parties

In the event of termination, expiration, or non-renewal of this Contract:

1. The obligations of the parties hereunder with regard to each Enrollee at the time of such termination, expiration or non-renewal will continue until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that EOHHS shall exercise best efforts to complete all disenrollment activities within six months from the date of termination, expiration, or non-renewal.

2. EOHHS shall be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive medical care;

3. The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for coverage of Enrollees for periods after the Effective Date of their Disenrollment; and

4. The Contractor shall supply to EOHHS all information necessary for the payment of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims shall be paid to the Contractor accordingly.

5. If the Contractor has Continued Obligations as described in this section, the Contractor shall accept the Risk-Adjusted Capitation Rate as established by EOHHS for the Contract Year during which the Continued Obligations period is occurring, with a 1.5% reduction, subject to actuarial soundness as appropriate, as payment in full for ACO Covered Services and all other services required under this Contract until all Enrollees have been disenrolled from the Contractor’s Plan;

6. EOHHS shall calculate Gain and Loss as described in **Appendix D**, if any, from the end of the Contract Year in which the termination is effective through the completion of all

disenrollment activities. The Contractor shall pay EOHHS the MassHealth Share of any Gain. EOHHS shall not be obligated to pay the Contractor the MassHealth Share of any Loss

7. The Contractor shall, to facilitate the transition of Enrollees to another MassHealth ACO, MCO, or the PCC Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment, Enrollees in care management, Enrollees with active prior authorizations, and Enrollees' active drug prescriptions.

8. The Contractor shall continue to meet all payment requirements under the Primary Care Sub-Capitation Program as set forth in **Section 2.23.A.1.h** and **Section 2.6.E.8** and shall not reduce any payment amount.

Section 5.7 Contract Term

This Contract shall be in effect as of the Contract Effective Date and end on December 31, 2027, subject to (1) the Contractor's acceptance of Capitation Rates as determined by EOHHS under this Contract; (2) the Contractor's satisfactory performance, as determined by EOHHS, of all duties and obligations under this Contract; and (3) the provisions of **Section 5.6**; provided, however that EOHHS may extend the Contract in any increments up to December 31, 2032, at the sole discretion of EOHHS, upon terms agreed upon by the parties. EOHHS reserves the right to further extend the Contract for any reasonable increment it determines necessary to complete a subsequent procurement. Extension of the Contract resulting from this RFR is subject to mutual agreement on terms by both parties, further legislative appropriations, continued legislative authorization, and EOHHS' determination of satisfactory performance.

Section 5.8 Additional Modifications to the Contract Scope

In its sole discretion, EOHHS may, upon written notice to the Contractor:

A. Modify ACO Covered Services, including but not limited to services related to Behavioral Health services;

B. Modify access and availability requirements;

C. Implement standardized provider credentialing policies and procedures;

D. Implement new Encounter Data reporting formats, including HIPAA 837 standards or X12 837 Post-Adjudicated Claims Data Reporting (PACDR) standards for submission of professional, institution, and dental Encounters and NCPDP format for submission of pharmacy Encounters as well as 277CA for reporting errors, not including Provider or Enrollee supplemental files;

E. Expand managed care eligible Members to include detained or incarcerated individuals in County Correctional Facilities, the Department of Correction, or hardware-secure facilities operated by the Department of Youth Services;

F. Implement collective accountability in incentive payments, wherein incentives are tied to collective outcomes across all ACOs rather than outcomes that result from each ACO individually;

G. Implement a Behavioral Health Compliance Withhold, wherein EOHHS withholds a percentage of the Contractor's Estimated Capitation Payment. The Contractor may earn back the withhold based on its performance on behavioral health-related activities and requirements, such as network availability and access, quality metrics, implementing EOHHS initiatives in a timely fashion, and minimizing the number of Enrollees awaiting placement in Emergency Departments; and

H. Modify the scope of this Contract to implement other initiatives in its discretion consistent with Delivery System Reform efforts or other MassHealth policy or goals.

Section 5.9 Amendments

A. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto. Further, the Contractor agrees to take such action as is necessary to amend this Contract in order for EOHHS to comply with all applicable state and federal laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Amendments of 1997 (BBA) and any regulations promulgated thereunder, the Deficit Reduction Act, and Health Care Reform, as well as any regulations, policy guidance, and policies and procedures related to any such applicable state and federal laws. EOHHS additionally reserves the right, at its sole discretion, to amend the Contract to implement judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS or the Contract. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.

B. EOHHS and Contractor mutually acknowledge that unforeseen policy, operational, methodological, or other issues may arise throughout the course of this Contract. Accordingly, EOHHS and Contractor agree to work together in good faith to address any such circumstances and resolve them, and if necessary, will enter into amendments to this Contract on mutually agreeable terms.

C. EOHHS reserves the right to amend the Contract to implement new initiatives or to modify existing initiatives, including enrolling additional Enrollees over the term of the Contract, or reducing current enrollment levels.

1. Possible EOHHS initiatives that could change enrollment include, but are not limited to:

a. Optional or mandatory enrollment of individuals under age 21 with Medicare or other third-party health insurance;

b. Optional or mandatory enrollment of individuals aged 21 and over with Medicare or other third-party health insurance;

c. Optional or mandatory enrollment of individuals aged 65 and older; and

d. Optional or mandatory enrollment of individuals who are enrolled in MassHealth's community first 1115 demonstration project, or other 1115 demonstration projects.

e. Optional or mandatory enrollment of individuals who are incarcerated

2. Other possible EOHHS initiatives include but are not limited to:

a. New EOHHS programs or information technology systems including but not limited to managed care programs and enrollment policies, accountable care organization and other payment reform initiatives;

b. Expansion of, or changes to, existing EOHHS programs, services, covered benefits, or information technology systems including but not limited to programs related to managed care programs and enrollment policies, accountable care organizations and other payment reform initiatives, and emergency services programs.

c. Expanding services for which the Contractors are accountable or responsible for arranging and providing, including but not limited to long-term services and supports;

d. Other programs as specified by EOHHS; and

e. Programs or information technology systems resulting from state or federal legislation, including but not limited to the patient protection and affordable care act (aca) of 2010, and regulations, initiatives, or judicial decisions that may affect in whole or in part EOHHS or the contract.

D. Other Enrollment Changes

EOHHS shall have the right in its sole discretion to increase or decrease enrollment of Enrollees over the term of the Contract for the following reasons:

1. Changes in EOHHS's methodology by which assignments are made to MassHealth managed care plans or ACOs;

2. Expansion of or changes to existing MassHealth programs, benefit packages, or services;

3. Changes in MassHealth Coverage Types, including the creation or elimination of covered populations;

4. Programs resulting from state or federal legislation, regulatory initiatives, or judicial decisions that may affect, in whole or in part, any component of this Contract; and

5. Extension of MassHealth managed care eligibility to individuals who are Incarcerated in County Correctional Facilities, the Department of Correction, or hardware-secure facilities operated by the Department of Youth Services.

a. Such coverage may be limited to a time period after an individual enters into custody and a time period before an individual's expected release date.

b. The Contractor may also be required to perform activities associated with the extension of eligibility, such as coordinating closely with Correctional Partners; ensuring timely access to care; ensuring timely provision of medical records; supporting care planning and care management; and coordinating with ongoing CSP-JI activities.

E. As needed, EOHHS shall issue a Contract amendment to implement any such initiative or program modification. The Contract amendment shall set forth the terms and conditions for any such initiative or program modification. EOHHS reserves the right to modify the Contract, including but not limited to, Capitation Rates, due to program modifications.

Section 5.10 Order of Precedence

The Contractor's response specified below is incorporated by reference into this Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

A. This Contract, including any Appendices and amendments hereto;

B. The Request for Responses for Accountable Care Organizations issued by EOHHS on April 13, 2022, and

C. The Contractor's Response to the RFR.

Section 5.11 Written Notices

Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To EOHHS:

Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Director, MassHealth ACO Program
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

With Copies to:
General Counsel
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor

Boston, MA 02108

To the Contractor:

Notice to the Contractor will be provided to the individual identified in **Appendix R**.

APPENDIX A
ACO REPORTING REQUIREMENTS

This Appendix summarizes the reporting requirements described in the Contract. EOHHS may update these requirements from time to time. The Contractor shall submit corresponding Certification Checklists of all reports/submissions listed in **Appendix A** within the timelines specified herein. The Contractor may include a narrative summary to reports/submissions and may include graphs that explain and highlight key trends. All reports must be submitted via OnBase, the EOHHS Contract Management system, unless otherwise indicated below in the *"Target System"* column. Numbering sequence and Report Title that will appear in the OnBase system can be found in **BOLD** in the *"Name of Report"* column.

For all of the reports listed below, unless otherwise specified, if the Contractor meets the target for a given report, the Contractor shall only complete a short narrative description on the report cover sheet. For any report that indicates that the Contractor is not meeting the target, the Contractor shall submit a detailed narrative that includes the results, an explanation as to why the Contractor did not meet the target, and the steps the Contractor is taking to improve performance going forward.

The Contractor shall provide all Reports in the form and format required by EOHHS and shall participate with EOHHS in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate. Targets shall be changed to reflect improvement in standards over time.

All exhibits referenced herein pertain to **Appendix A**, unless otherwise noted. Such exhibits set forth the form and format the Contractor shall use for each report below. These exhibits shall be provided to the Contractor and may be updated by EOHHS from time to time. EOHHS shall notify the Contractor of any updates to the exhibits.

Reporting Deliverable Schedule

1. **Same Day Notification (Immediate Notice Upon Discovery):** Deliverables due the same day as discovery. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.
2. **Next Day Notifications:** Deliverables due the next day. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.
3. **Two Business Days Notification:** Deliverables due in two business days
4. **Weekly Deliverables:** Deliverables due by close of business/COB on Fridays
5. **Within 7 Calendar Days of Occurrence Notification:** Deliverables due within seven calendar days of occurrence. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due within 7 calendar days of the next business day.
6. **No later than 30 days prior to execution:** Deliverables due thirty days prior to implementation for review and approval by EOHHS.
7. **Monthly Deliverables:** Deliverables due on a monthly basis, by the last day of the month, following the month included in the data, unless otherwise specified by EOHHS.
8. **Quarterly Deliverables:** Deliverables due on a contract year (CY) quarterly basis, by the last business day of the month following the end of each quarter, unless otherwise specified.

   CY Quarter 1: January 1 – March 31

   CY Quarter 2: April 1 - June 30

   CY Quarter 3: July 1 – September 30

   CY Quarter 4: October 1 – December 31
9. **Semi-Annual Deliverables:** Deliverables due by the last business day of the month following the end of the reporting period, unless otherwise specified. The semi-annual reporting periods are as follows:

   January 1 – June 30

   July 1 – December 31
10. **Annual Deliverables**: Deliverables due by the last business day of the month following the end of the reporting period (Contract Year: January 1 -- December 31), unless otherwise specified by EOHHS.
11. **Ad-Hoc Deliverables**: Deliverables are due whenever the Contractor has relevant changes or information to report, or upon EOHHS request related to Behavioral Health, Contract Management, Financial, Quality, Pharmacy, and Operations deliverables as applicable.

A. Report and Compliance Certification Checklist: Exhibit C-1

Annually - The Contractor shall list, *check off,* sign and submit a Certification of Data Accuracy for all Contract Management (also including Coordination of Benefits, Hospital Utilization, Fraud and Abuse, Encounter Data and Drug Rebate claims data), Behavioral Health, Financial, Operations and Quality reports/submissions, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of the Contractor's knowledge, information and belief, after reasonable inquiry. For each report in the sections below, if an attestation is required with the submission, that information will be included within the reporting template.

B. Contract Management Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-03	**CM-03 Member Telephone Statistics** Member Telephone Statistics	Monthly	OnBase
CM-04	**CM-04 Member Education and Related Orientation, Outreach Materials** Member Education and Related Orientation, Outreach Materials (including enrollment materials for MH Customer Service Center (CSC)	Ad-Hoc	Secure Email
CM-05	**CM-05 Updated Provider Directory** Provider Directory	Ad-Hoc	OnBase
CM-06	**CM-06 Provider Manual** Provider Manual	Ad-Hoc	OnBase
CM-07	**CM-07 Marketing Materials** Marketing Materials *(60 days in advance of use, including materials to be distributed at Contractor and non-Contractor sponsored health fairs or community events)*	Ad-Hoc	Secure Email
CM-08	**CM-08 Marketing Materials- Annual Executive Summary** Marketing Materials- Annual Executive Summary (including a written statement that all of the Contractor's marketing plans and materials are accurate and do not mislead, confuse, or defraud Members or the state)	Annually	OnBase
CM-09	**CM-09 Significant Changes in Provider Network Notification** Significant Changes in Provider Network Notification. (Notification: Same Day)	Ad-Hoc	OnBase
CM-10 [all]	**[RETIRED]**		

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-11	**CM-11 Access and Availability-Immediate Notification** Access and Availability-Immediate Notification to EOHHS (only if changes occur that may impact Enrollee access to care, relative to contract standards for geographic access and PCP to enrollee ratio)	Ad-Hoc	OnBase
CM-12	**CM-12 Claims Processing Report** Claims Processing Report	Monthly	OnBase
CM-13	**CM-13 Provider Financial Audit** Provider Financial Audit	Annually	OnBase
CM-14	**[RETIRED]**		
CM-15	**CM-15 Notification of Scheduled Board of Hearing Cases** Notification of Board of Hearing Cases (Notification: Same Day)	Ad-Hoc	OnBase and secure e-mail
CM-16	**CM-16 Implementation of Board of Hearing Decision** Implementation of Board of Hearing Decision (within 30 days of receipt)	Ad-Hoc	OnBase
CM-17-A	**CM-17-A Enrollee Inquiries Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Inquiries	Annually	OnBase
CM-17-B	**CM-17-B Enrollee Grievances Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Grievances	Annually	OnBase
CM-17-C	**CM-17-C Enrollee Internal Appeals Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Internal Appeals	Annually	OnBase
CM-17-D	**CM-17-D Enrollee Board of Hearing Appeals Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee BOH Appeals	Annually	OnBase
CM-17-E	**CM-17-E - Appeals Report (per 1,000 Enrollees)** Appeals Report (per 1,000 Enrollees)	Monthly	OnBase
CM-17-F	**CM-17-F - Grievances Report (per 1,000 Enrollees)** Grievances Report (per 1,000 Enrollees)	Monthly	OnBase
CM-18	**[RETIRED]**		
CM-19	**[RETIRED]**		
CM-20	**[RETIRED]**		
CM-21	**[RETIRED]**		

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-22	**CM-22 ACO/MCO Organization and Key Personnel Changes** Organization and Key Personnel Changes. The Contractor will also include Behavioral Health subcontractor information if applicable.	Ad-Hoc	OnBase
CM-23	**CM-23 Notification of Termination of Material Subcontractor** Notification of Intention to Terminate a Material Subcontractor (Notification: Same Day)	Ad-Hoc	OnBase
CM-24	**CM-24 Notification of New Material Subcontractor** Notification of Intention to Use a New Material Subcontractor (Submit the checklist 60 days prior to requested implementation date)	Ad-Hoc	OnBase
CM-25	**CM-25 Material Subcontractor List Annual Summary** Material Subcontractor List Annual Summary	Annually	OnBase
CM-26	**CM-26 Coordination of Benefits / Third Party Liability Report (Appendix H)** Coordination of Benefits / Third Party Liability Report (Appendix H) a. Third Party Health Insurance Cost Avoidance Claims Amount by Carrier b. Third Party Health Insurance Total Recovery Savings by Carrier c. Accident Trauma Recoveries d. Accident/Trauma Cost Avoidance.	Semi-Annually	OnBase
CM-27	**CM-27 Third Party Liability (TPL) Identification Reporting (Appendix H)** 1. TPL Indicator Form 2. Other EOHHS-specified electronic TPL reporting	Ad-Hoc	1. Mail or Fax (FPL Indicator Form only) 2. Electronic Submission as further specified by EOHHS
CM-28	**CM-28 Benefits Coordination Structure (Appendix H)** Benefits Coordination Structure (Appendix H)	Ad-Hoc	OnBase
CM-29	**CM-29 Encounter Data Submission (Appendix E)** Encounter Data Submission (Appendix E)	Monthly	Data Warehouse

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-30	**CM-30 Sampling of Enrollees To Ensure Services Received** Sampling of Enrollees To Ensure Services Received Were The Same as Providers Billed	Annually	OnBase
CM-31	**CM-31 Notification of Federally Required Disclosures** Notification of Federally Required Disclosures (in accordance with Section 5.1.O)	Ad-Hoc	OnBase
CM-32	**CM-32 Notification of Reportable Findings /Network FRD** Notification of Reportable Findings /Network FRD (Notification: Same Day)	Ad-Hoc	OnBase
CM-33	**CM-33 Summary of Reportable Findings/Network FRD Forms** Summary of Reportable Findings/Network FRD Forms	Annually	OnBase
CM-34	**[RETIRED]**		
CM-35	**[RETIRED]**		
CM-36	**CM-36 Provider Materials** Provider Materials (related to enrollee cost-sharing, changes to Covered Services and/or any other significant changes per contractual requirements)	Ad-Hoc	OnBase
CM-37	**CM-37 ACO/MCO Policies and Procedures** ACO/MCO Policies and Procedures (New drafts and any changes to the most recent printed and electronic versions of the Provider procedures and policies which affect the process by which Enrollees receive care (relating to both medical health and Behavioral Health, if separate) for prior review and approval).	Ad-Hoc	OnBase
CM-38	**[RETIRED]**		
CM-39	**CM-39 PCP/Enrollee assignment Monthly report** PCP/Enrollee assignment report	Monthly	Data Warehouse
CM-40	**CM-40 PCP/Enrollee assignment report Ad-Hoc** PCP/Enrollee assignment report	Ad-hoc	Data Warehouse
CM-41	**CM-41 Excluded Provider Monitoring Report** Excluded Provider Monitoring Report	Monthly	OnBase
CM-43-A	**CM-43-A Holiday Closures and Other Contractor Office Closures Annual** Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annually	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-43-B	**CM-43-B Emergency Closures and Other Contractor Office Closures Ad Hoc** Emergency Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Ad Hoc	OnBase
CM-44	**CM-44 Strategy-related Reports** Strategy-related Reports	Ad Hoc	OnBase
CM-45	**[RETIRED]**		
CM-46	**CM-46 Enrollee and Provider Incentives Notification** Enrollee and Provider Incentives Notification	Ad-Hoc	OnBase
CM-47	**[RETIRED]**		
CM-48	**CM-48 Copy of Press Releases (pertaining to MassHealth line of business)** Copy of Press Releases (pertaining to MassHealth line of business)	Ad-Hoc	OnBase
CM-49	**CM-49 Written Disclosure of Identified Prohibited Affiliations** Written Disclosure of Identified Prohibited Affiliations	Ad-Hoc	OnBase
CM-50	**[RETIRED]**		
CM-51	**[RETIRED]**		
CM-52	**[RETIRED]**		
CM-53	**CM-53 Involuntary Change in PCP Report** Involuntary Change in PCP Report	Ad-Hoc	OnBase
CM-54-A	**CM-54-A Hospital Payment Arrangement Report** Hospital Payment Arrangement Report	Annually	OnBase
CM-54-B	**CM-54-B Hospital Fee Schedule Exemption Form** Hospital Fee Schedule Exemption Form	Ad-Hoc	OnBase
CM-55-A	**CM-55-A Summary of A&A: Ensuring Enrollees access to Medically Necessary services** Summary of Access and Availability: Description of Ensuring Enrollees have access to Medically Necessary services	Annually	OnBase
CM-55-A-ADH	**CM-55-A-ADH Summary of A&A: Ensuring Enrollees access to Medically Necessary services** Summary of Access and Availability: Description of Ensuring Enrollees have access to Medically Necessary services	Ad-Hoc	OnBase
CM-55-B	**CM-55-B Network Provider Lists: PCPs and OB/GYNs** Network Provider Lists: PCPs and OB/GYNs	Annually	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-55-B-ADH	**CM-55-B-ADH Network Provider Lists: PCPs and OB/GYNs** Network Provider List: PCPs and OB/GYNs	Ad-Hoc	OnBase
CM-55-C	**CM-55-C Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers** Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers	Annually	OnBase
CM-55-C-ADH	**CM-55-C-ADH Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers** Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers	Ad-Hoc	OnBase
CM-55-D	**CM-55-D Network Provider Lists: Physician Specialists** Network Provider Lists: Physician Specialists	Annually	OnBase
CM-55-D-ADH	**CM-55-D-ADH Network Provider Lists: Physician Specialists** Network Provider Lists: Physician Specialists	Ad-Hoc	OnBase
CM-55-E	**CM-55-E Network Provider List: Pharmacies** Network Provider List: Pharmacies	Annually	OnBase
CM-55-E-ADH	**CM-55-E-ADH Network Provider List: Pharmacies** Network Provider List: Pharmacies	Ad-Hoc	OnBase
CM-55-F	**CM-55-F Ratio Reports: PCP to Enrollee and OBGYN to Enrollee (female members age 10+)** Showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees/OBGYN ratios for female members age 10+)	Annually	OnBase
CM-55-F-ADH	**CM-55-F-ADH Ratio Reports: PCP to Enrollee and OBGYN to Enrollee (female members age 10+)** Showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees/OBGYN ratios for female members age 10+)	Ad-Hoc	OnBase
CM-55-G	**CM-55-G Ratio Reports: Specialist to Enrollee** Specialists to Enrollee Ratio	Annually	OnBase
CM-55-G-ADH	**CM-55-G-ADH Ratio Reports: Specialist to Enrollee** Specialists to Enrollee Ratio	Ad-Hoc	OnBase
CM-55-H	**CM-55H Distance and time reports: PCP and OBGYN provider** Distance and time reports: PCP and OBGYN provider	Annually	OnBase
CM-55-H-ADH	**CM-55-H-ADH Distance and time reports: PCP and OBGYN provider** Distance and time reports: PCP and OBGYN provider	Ad-Hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-55-I	**CM-55-I Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers** Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers	Annually	OnBase
CM-55-I-ADH	**CM-55-I-ADH Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers** Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers	Ad-Hoc	OnBase
CM-55-J	**CM-55-J Distance and time reports: Physician Specialists** Distance and time reports: Physician Specialists	Annually	OnBase
CM-55-J-ADH	**CM-55-J-ADH Distance and time reports: Physician Specialists** Distance and time reports: Physician Specialists	Ad-Hoc	OnBase
CM-55-K	**CM-55-K Distance and time reports: Pharmacies** Distance and time reports: Pharmacies	Annually	OnBase
CM-55-K-ADH	**CM-55-K-ADH Distance and time reports: Pharmacies** Distance and time reports: Pharmacies	Ad-Hoc	OnBase
CM-55-L	**CM-55-L Timeliness of Care** Summary of Access and Availability: Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards)	Monthly	OnBase
CM-55-L-ADH	**CM-55-L-ADH Timeliness of Care** Summary of Access and Availability: Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards)	Ad-Hoc	OnBase
CM-55-M	**CM-55-M Use of Out-of- Network Providers** Summary of Access and Availability: Use of Out-of- Network Providers	Annually	OnBase
CM-55-M-ADH	**CM-55-M-ADH Use of Out-of- Network Providers** Summary of Access and Availability: Use of Out-of- Network Providers	Ad-Hoc	OnBase
CM-56	**CM-56 CMS Managed Care Program Annual Report (MCPAR)** CMS Managed Care Program Annual Report (MCPAR)	Annually	OnBase
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annually	OnBase
CM-TBD	**Material Subcontractor Checklist**	Ad-Hoc	TBD

C. Behavioral Health Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
BH-01	**BH-01 Reportable Adverse Incidents-Daily Incident Delivery Report** Behavioral Health Reportable Adverse Incidents and Roster of Reportable Adverse Incidents-Daily Incident Delivery Report (Notification: Same Day)	Notification: Same Day	Secure Email
BH-02	**BH-02 Behavioral Health Adverse Incident Summary Report** Behavioral Health Adverse Incident Summary Report	Annually	OnBase
BH-03	**BH-03 Behavioral Health Readmission Rates** Behavioral Health Readmission Rates	Annually	OnBase
BH-04	**BH-04 Behavioral Health Ambulatory Continuing Care Rates** Behavioral Health Ambulatory Continuing Care Rates	Annually	OnBase
BH-05	**BH-05 Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status.** Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status.	Daily	MABHA Website
BH-06	**BH-06 Enrollee Access to ESP** Enrollee Access to ESP	Ad hoc	OnBase
BH-08	**[RETIRED]**		
BH-11	**BH-11 Behavioral Health Medical Records Review Report** Behavioral Health Medical Records Review Report	Annually	OnBase
BH-12	**BH-12 Annually Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria** Annual Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria	Annually	OnBase
BH-13	**BH-13 Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report** Behavioral Health Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report	Quarterly	OnBase
BH-14	**BH-14 CANS Compliance Report** CANS Compliance. This report is required when CANS data is made available through the Virtual Gateway	Quarterly	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
BH-15	**BH-15 Behavioral Health Utilization and Cost Report** Behavioral Health Utilization and Cost Report	Quarterly	OnBase
BH-17	**BH-17 Behavioral Health Inquiries, Grievances, Internal Appeals and BOH** Behavioral Health Inquiries, Grievances, Internal Appeals and BOH	Annually	OnBase
BH-18	**BH-18 Behavioral Health Provider Network Access and Availability** Behavioral Health Provider Network Access and Availability	Ad-hoc and Annually	OnBase
BH-19	**BH-19 Behavioral Health Telephone Statistics** Behavioral Health Telephone Statistics	Annually	OnBase
BH-22	**BH-22 Substance Use Disorder Clinical Ops/Inpatient Authorization Report** Substance Use Disorder Clinical Operations/Inpatient & Acute Service Authorization Modification and Denial Report	Quarterly	OnBase
BH-23	**BH-23 Behavioral Health Fraud and Abuse Report** Fraud and Abuse Report	Quarterly	OnBase
BH-24	**BH-24 Community Support Program for Chronically Homeless Individuals Provider List** Community Support Program for Chronically Homeless Individuals Provider List	Annually	OnBase
BH-25	**BH-24 Community Support Program for Individuals with Justice Involvement Provider List** Community Support Program for Individuals with Justice Involvement Provider List	Quarterly	OnBase
BH-26	**BH-26: Community Support Program Tenancy Preservation Program Provider List** Community Support Program Tenancy Preservation Program Provider List	Annually	OnBase

D. Care Coordination

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CC-01	**CC-01 Care Needs Screening** Aggregate Care Needs Screening Completion Rates	Ad-hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CC-02	**CC-02 HRSN Screening** HRSN Screening Completion Rates	Monthly	TBD
CC-03	**CC-03 HRSN Referrals** HRSN Referral Rate	Ad-hoc	TBD
CC-04	**CC-04 Risk Stratification Algorithm** Risk Stratification Algorithm and Narrative	Annually	OnBase
CC-05	**CC-05 Care Management Program Descriptions and Performance** Care Management Program Descriptions and Performance	Annually	OnBase
CC-06	**CC-06 CP Program Descriptions and Performance** CP Program Descriptions and Performance	Annually	OnBase
CC-07-A	**CC-7-A CP Payment Receipts** CP Payment Receipts	Annually	TBD
CC-07-B	**CC-07-B CP Payment Receipts** CP Payment Receipts	Monthly	TBD
CC-08	**CC-08 CP Performance and Corrective Action Plans** CP Performance and Corrective Action Plans	Ad hoc	OnBase
CC-9	**CC-9 Comprehensive Assessment and Care Plans (CP and CM)** Comprehensive Assessment and Care Plan Completion Rates for Care Management and Community Partners	Ad hoc	OnBase
CC-10	**CC-10 Care Management Enrollment** Care Management Enrollment	Monthly	TBD
CC-11	**CC-11 Care Management Program Budget** Care Management Program Budget	Annual	OnBase

E. Financial Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-01	**FR-01 Notification to EHS Regarding Negative Change in Financial Status** Notification to EHS Regarding Negative Change in Financial Status (Notification: Same Day)	Ad-Hoc Notification: Same Day	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-02	**FR-02 Outstanding Litigation Summary** Outstanding Litigation Summary	Annually	OnBase
FR-03	**FR-03 Financial Ratio Analysis** Financial Ratio Analysis\	Annually	OnBase
FR-04B	**FR-04B Experience Review and Revenue Expense Report (F-4B)** Experience Review and Revenue Expense Report (F-4B)	Quarterly and Annually	OnBase
FR-05C	**FR-05C Experience Review and Utilization/Cost Reports (F-5C)** Experience Review and Utilization/Cost Reports (F-5C)	Quarterly and Annually	OnBase
FR-07	**FR-07 Liability Protection Policies** Liability Protection Policies	Annually	OnBase
FR-08	**FR-08 DOI Financial Report (for Plans that are DOI licensed)** DOI Financial Report (for Plans that are DOI licensed)	Quarterly	OnBase
FR-09	**FR-09 Insolvency Reserves** Insolvency Reserves Attestation	Annually	OnBase
FR-10	**FR-10 Lag Triangles and Completion Factors Report (IBNR)** Lag Triangles and Completion Factors Report (IBNR)	Quarterly and Annually	OnBase
FR-11	**FR-11 Description of Incurred But Not Reported (IBNR) Methodology** Description of Incurred But Not Reported (IBNR) Methodology	Annually	OnBase
FR-12	**FR-12 Audited Financial Statements** Audited Financial Statements	Annually	OnBase
FR-13	**FR-13 Attestation Report from Independent Auditors on Effectiveness of Internal Controls** Attestation Report from Independent Auditors on Effectiveness of Internal Controls	Annually	OnBase
FR-14	**FR-14 Financial Relationships Report** Financial Relationships Report	Annually	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-15	**FR-15 Annual Administrative Detail Report** Annual Administrative Detail Report	Annually	OnBase
FR-17	**FR-17 Quarterly Risk Share Report** Quarterly Annual Risk Share Report	Quarterly and Annually	OnBase
FR-18-A	**[RETIRED]**		
FR-18-B	**[RETIRED]**		
FR-19	**FR-19 Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year** Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year	Ad-Hoc	OnBase
FR-20	**[RETIRED]**		
FR-21	**[RETIRED]**		
FR-22	**[RETIRED]**		
FR-23	**FR-23 Ad Hoc Cash Flow Statement** Ad Hoc Cash Flow Statement	Ad-Hoc	OnBase
FR-24	**FR-24 Report on Any Default of the Contractor's Obligations OR Financial Obligation To A Third Party.** 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. (Notification should be given Same Day)	Ad-Hoc	OnBase
FR-25	**FR-25 Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures** Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures That May Impact Performance (No later than 30 days prior to execution)	Ad-Hoc No later than 30 days prior to execution	OnBase
FR-26	**FR-26 Provider Risk Arrangements** Provider Risk Arrangements	Ad-Hoc	OnBase
FR-27	**FR-27 Changes in Contractor's Providers' Risk Arrangements** Changes in Contractor's Providers' Risk Arrangements (Notification: Same Day)	Ad-Hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-28	**FR-28 Working Capital Requirement Notification** Working Capital Requirement Notification ("if" working capital falls below 75% below the amount reported on the prior year audited financial reports) (Two Business Days)	Ad-Hoc	OnBase
FR-29	**FR-29 Continuing Services Reconciliation Data** Continuing Services Reconciliation Data	Ad-Hoc	OnBase
FR-30	**FR-30 ABA Reconciliation Report** ABA Reconciliation Report	Annually	OnBase
FR-31	**FR-31 Medical Loss Ratio (MLR) Report** Medical Loss Ratio (MLR) Report	Annually	OnBase
FR-32	**FR-32 Alternative Payment Models (APM) Report** Alternative Payment Models (APM) Report	Quarterly	OnBase
FR-33	**FR-33 Provider Agreements Annual** Provider Agreements Annual	Annually	OnBase
FR-34	**FR-34 Provider Agreements – Ad-Hoc** Provider Agreements – Ad-Hoc	Ad-Hoc	OnBase
FR-35	**FR-35 Report on Satisfying Contractor's Payment Or Performance Obligations** Report on Satisfying Contractor's Payment Or Performance Obligations	Ad-Hoc	OnBase
FR-37	**FR-37 IMD Services Report** Report on services provided to members with long term IMD stay	Quarterly and Annually	OnBase
FR-38	**FR-38 Other High Cost Pharmacy Reconciliation Report** Annual Other High Cost Pharmacy Risk Share Report	Annually	OnBase
FR-39	**FR-39 SUD Reconciliation Report** Annual SUD Risk Share Report	Annually	OnBase
FR-40	**FR-40 Financial Encounter Validation Report** Quarterly Financial Encounter Validation Report	Quarterly and Annually	OnBase
FR-41	**[RETIRED]**		
FR-42	**[RETIRED]**		

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-43	**FR-43 Primary Care Sub-Capitation Financial Report** Quarterly and Annual Primary Care Subcap Financial Report	Quarterly and Annually	OnBase
FR-44	**FR-44 Community Partners Financial Report** Quarterly and Annual Community Partners Financial Report	Quarterly and Annually	OnBase

F. ACO Health Equity Reporting

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	To be determined.		

G. Operations Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
OP-01	**[RETIRED]**		POSC
OP-02	**OP-02 Inbound Managed Care Provider Directory Interface (ACPD)** Inbound Managed Care Provider Directory Interface (ACPD)	Monthly	POSC
OP-03	**OP-03 Long-term Care Report Log** Long-term Care Report Log	Weekly	OnBase
OP-04	**OP-04 Member Discrepancy Report** Member Discrepancy Report	Monthly	OnBase
OP-05	[**RETIRED**]		
OP-06	**OP-06 Address Change File** Address Change File	Bi-Weekly	OnBase
OP-07	**OP-07 Multiple ID File** Multiple ID File	Bi-Weekly	OnBase
OP-08	**OP-08 Date of Death Report** Date of Death Report	Bi-Weekly	OnBase
OP-09	**OP-09 Cost Sharing Copay Overage Report** Cost Sharing Copay Overage Report	Monthly	OnBase

H. Pharmacy Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-01	**PH-01 Pharmacy Claims Level Interface** Plans use the Pharmacy Claims Level Interface to submit rebate data for Pharmacy claims**.** The original claims file submission is due **within 5 calendar days** following the close of the prior month.	Monthly	POPS Portal
PH-02	**[RETIRED]**		
PH-03	**PH-03 Pharmacy Provider Network Identification Layout** Pharmacy Provider Network Identification Layout	Ad-Hoc	POPS Portal
PH-04-A	**PH-04-A Drug Utilization Review Report** Drug Utilization Review Report *(Note: Due by May 1st of each year)*	Annually	Secure Email
PH-04-B	**PH-04-B Clinical Information request for the DUR Board meeting** Clinical Information request for the DUR board meeting	Ad-Hoc	Email
PH-04-C	**PH-04-C Clinical Criteria for Prior Authorization and Utilization Management** Clinical Criteria for Prior Authorization and Utilization Management	Ad-Hoc	Email
PH-05-A	**PH-05-A Pharmacy MassHealth Drug Rebate File Submission Report** Pharmacy MassHealth Drug Rebate File Submission Report for the plans to self- report monthly on the upload of the report PH-01 to the POPS Portal. The File Submission Report is due within 3 business days following the upload of PH-01.	Monthly	Email
PH-05-B	**[RETIRED]**		
PH-06	**[RETIRED]**		
PH-07	**PH-07 Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal** Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal	Ad-Hoc	OnBase
PH-08	**PH-08 Clinical Policy Initiative Report** Clinical Policy Initiative Report	Ad-Hoc	OnBase
PH-09	**PH-09 MassHealth ACO/MCO Uniform Preferred Drug List Compliance Report** MassHealth ACO/MCO Uniform Preferred Drug List Compliance Repor**t**	Ad-Hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-10	**PH-10 Hepatitis C Utilization Report** Hepatitis C Utilization Report	Ad-Hoc	OnBase
PH-11	**PH-11 Pediatric BH Medication Initiative Report** Pediatric BH Medication Initiative Report	Ad-Hoc	OnBase
PH-12-A	**PH-12-A PBM Pricing Report - Quarterly** PBM Pricing Report- Quarterly	Quarterly	POPS Portal, or as directed by EOHHS
PH-12-B	**PH-12-B PBM Pricing Report - Ad-Hoc** PBM Pricing Report- Ad-Hoc	Ad-Hoc	POPS Portal, or as directed by EOHHS
PH-13	**PH-13 Mail Order Pharmacy Program Report** Mail Order Pharmacy Program Report- Ad-Hoc	Ad-Hoc	OnBase
PH-14	**PH-14 Change in BIN/PCN/Group Number Report** Change in BIN/PCN/Group Number Report- Ad-Hoc *(Note: Due at least 30-days before new BIN/PCN/Group Number is effective)*	Ad-Hoc	OnBase
PH-15	**PH-15 Vitrakvi Monitoring Report** Vitrakvi Monitoring Report- Quarterly	Quarterly	OnBase
PH-16-A	**PH-16-A Zolgensma Monitoring Program- Quarterly** Zolgensma Monitoring Program- Quarterly	Quarterly	OnBase
PH-16-B	**PH-16-B Zolgensma Monitoring Program- Annual** Zolgensma Monitoring Program- Annual	Annually	OnBase
PH-17	**PH-17 CAR-T Monitoring Program** CAR-T Monitoring Program-Quarterly	Quarterly	OnBase
PH-18	**PH-18 Controlled Substance Management Program Enrollees Leaving Health Plan** Controlled Substance Management Program Enrollees Leaving Health Plan- Monthly	Monthly	OnBase
PH-19	**PH-19 Givlaari Monitoring Program** Givlaari Monitoring Program – Annual *(Note: Due by the last business day of April each year)*	Annually	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-20	**PH-20 Onpattro Monitoring Program** PH-20 Onpattro Monitoring Program - Quarterly	Quarterly	OnBase
PH-21	**PH-21 reSET and reSET-O Utilization** reSET and reSET-O Utilization	Quarterly	OnBase
PH-22-A	**PH-22-A 340B Contract Pharmacies -Annual** 340B Contract Pharmacies- Annual	Annually	OnBase
PH-22-B	**PH-22-B 340B Contract Pharmacies – Ad-Hoc** 340B Contract Pharmacies – Ad-Hoc	Annually	OnBase
PH-23- A	**PH-23-A 340B Margin Usage -Annual** **340B Margin Usage**	Annually	OnBase
PH-23-B	**PH-23-B 340B Margin Usage- Ad-Hoc** 340B Margin Usage- Ad-Hoc	Ad-Hoc	OnBase

I. Program Integrity

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PI-01	**PI-01 Fraud and Abuse Notification (within 10 days) and Activities** Fraud and Abuse Notification (within 10 days) and Activities	Ad-Hoc	OnBase and e-mail
PI-02	**PI-02 Notification of For-Cause Provider Suspensions and Terminations** Notification of Provider Suspensions and Terminations	Notification: Within 3 Business Days	OnBase
PI-03	**PI-03 Summary Report of For-Cause Provider Suspensions and Terminations** Summary Report of Provider Suspensions and Terminations	Annual	OnBase
PI-04	**PI-04 Notification of Provider Overpayments** Notification of Provider Overpayments	Ad-hoc	OnBase
PI-05	**PI-05 Summary of Provider Overpayments** Summary of Provider Overpayments	Semi-annually	OnBase
PI-06	**PI-06 Response to Overpayments Identified by EOHHS Report** Response to Overpayments Identified by EOHHS Report	Ad-hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PI-07	**PI-07 Agreed Upon Overpayments Collection Report** Agreed Upon Overpayments Collection Report	Ad-hoc	OnBase
PI-08	**PI-08 - Self-Reported Disclosures** Self-Reported Disclosures	Ad-Hoc	OnBase
PI-09	**PI-09 Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan** Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan	Annual	OnBase
PI-10	**PI-10 Payment Suspension** Quarterly Payment Suspension Report	Quarterly	OnBase

J. Quality Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-01	**QR-01 Quality Improvement Goals (Appendix B, QM/QI work plan)** Quality Improvement Goals (Appendix B) (Includes QM/QI Work plan). Report needs to be submitted as per Appendix B Reporting Timeline.)	Annually	OnBase
QR-02	**QR-02 CAHPS Reports (Submission of full CAHPS Report)** CAHPS Reports (Submission of full CAHPS Report as well Member-level and aggregate data made available via NCQA submission process)	Annually	OnBase
QR-03	**QR-03 External Research Project Notification** External Research Project Notification	Ad-Hoc	OnBase
QR-04	**QR-04 External Audit/Accreditation** External Accreditation (Submission of NCQA accreditation report and associated results)	Ad-Hoc	OnBase
QR-05	**QR-05 HEDIS IDSS Report** HEDIS IDSS Report (Submission in Excel and CSV formats).	Annually	OnBase
QR-06	**QR-06 HEDIS Member Level Data**	Annually	Email

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-07	**QR-07 Supplemental Data for Clinical Quality and Health Equity Measures** Supplemental data files (Format for submission determined and communicated by MassHealth's Comprehensive Quality Measure Vendor (CQMV).	Annually	Inter-change
QR-08	**QR-08 Validation of Performance Measures** Performance Measure Data (Format for submission determined and communicated by External Quality Review Organization).	Annually	EQRO
QR-09	**QR-09 Performance Improvement Projects** Performance Improvement Project Reports (Format for submission determined by and communicated by External Quality Review Organization).	Bi-Annually	EQRO
QR-10	**QR-10 Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)** Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs) (*including Health care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs) Submission using EOHHS developed template).*	Notification: Within 30 calendar days of occurrence	OnBase
QR-11	**QR-11 Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)** Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs) (Submission using EOHHS-developed template).	Annually	OnBase

APPENDIX B
Quality Improvement Goals

1. INTRODUCTION

This appendix describes the requirements for the Quality Improvement Goals, Performance Improvement Projects, and Performance Measures as specified in **Section 2.14** of the Contract.

2. QI GOAL IMPROVEMENT CYCLE

The QI Goal measurement cycle typically includes a planning/baseline period and several remeasurement phases to allow for tracking of improvement gains. For each QI Goal cycle, EOHHS will establish a series of QI goal domains and sub-domains as well as approve and/or designate measurement and quality improvement activities for each of those domains. The following paragraphs outline the CY23 QI Goal Cycle.

Performance Improvement Projects (PIPs) must be conducted in accordance with the guidance specified in Appendix B or otherwise be approved by EOHHS. Additionally, all PIPs must also be aligned with the quality performance measures outlined in Appendix Q of the contract, unless otherwise specified or approved by EOHHS. EOHHS or its designee will provide standardized forms for all required reporting activities, including Quality Improvement Plans, Progress Reports, and Annual Reports.

a. QI IMPLEMENATION DETAILS

Quality Measurement (QM) Focused PIP:
ACOs will be responsible for implementing a minimum of one PIP focused on improving the performance on at least one quality measure outlined in Appendix Q, Section 2.A. QM-focused PIPs should be informed by both MassHealth and ACO-organizational priorities. ACOs may elect to continue and/or expand on prior improvement activities.

Health Equity (HE) Focused PIPs:
To achieve significant and sustained improvement in equity outcomes and promote system wide impacts, ACOs will partner with acute hospitals to implement two health equity focused Performance Improvement Projects (PIPs). PIPs will be focused on two of three MassHealth-defined domain areas: 1) Care Coordination/Integration, 2) Care for Acute and Chronic Conditions, and 3) Maternal Morbidity.

APPENDIX B
Quality Improvement Goals

TABLE 1: QI GOAL IMPLEMENTATION PERIODS AND ASSOCIATED ACTIVITIES

Timeframe	*Activities*	*Deliverable*
CY23: April 1, 2023 – December 31, 2023	• Project planning and baselining for one ACO QM PIP • Project planning and baselining for one hospital-partnered PIP	• One Planning/Baseline Report for each PIP (total of two reports)
CY24: January 1, 2024 – December 31, 2024	• Implementation of one ACO QM PIP • Implementation of one hospital-partnered PIP • Project planning and baselining for second hospital-partnered PIP	• One Remeasurement Report for each implemented PIP (total of two reports) • One Planning/Baseline for second hospital-partnered PIP (total of 1 reports)
CY25: January 1, 2025-December 31, 2025	• Continuation of one ACO QM PIP from CY24 • Continuation of one hospital-partnered PIP from CY24 • Implementation of second hospital-partnered PIP	• One Remeasurement Report for each implemented PIP (total of 3 reports)

3. DOMAIN MEASURES AND INTERVENTIONS

ACOs shall identify specific measures and interventions within their PIPs that are reflective of the quality performance measures identified in Appendix Q.

4. ACO REPORTS, SUBMISSIONS, AND TEMPLATES

ACOs will submit Reports using the Submission Templates developed and distributed by EOHHS or its designee. QI Goal Reporting submissions shall include quantitative and qualitative data as well as specific progress made on each measure, barriers encountered, lessons learned, and planned next steps. For specific instructions on the submission process and detail on the submission templates, ACOs shall refer to guidance provided by EOHHS or its designee.

Evaluation of QI Reports: EOHHS or its designee will review QI Goal 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 ACOs for each implementation period.

Cultural Competency

Participating ACOs shall design and implement all QI Goal activities and interventions in a culturally competent manner.

5. PERFORMANCE MEASURES

EOHHS has defined performance measures pursuant to **Section 2.14.C.1** of the Contract and reserves the right to modify this of performance measures as deemed necessary and determined by EOHHS. The list of performance measures may be found in Appendix Q of this contract. In accordance with the Medicaid Managed Care Rule, the performance measures may be used by EOHHS to publicly report ACO performance. EOHHS reserves the right to withhold reporting of a measure(s) as determined by EOHHS. All measures referenced in Appendix Q are calculated by EOHHS (with clinical data submitted by the Accountable Care Partnership for hybrid measures).

6. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLANS

In accordance with **Section 2.14.B.5** of the Contract, ACPPs must submit to EOHHS an annual QI workplan that broadly describes ACPP QI initiatives that are conducted as part of the plan's comprehensive quality assurance and performance improvement (QAPI) program. The QI plan should minimally include the PIPs and performance measures referenced in Appendices B and Q.

APPENDIX C
Exhibit 1: ACO Covered Services
✓ Denotes a covered service

The Contractor shall provide to each Enrollee each of the ACO Covered Services listed below in an amount, duration, and scope that is Medically Necessary (as defined in **Section 1** of this Contract), provided that the Contractor is not obligated to provide any ACO Covered Service in excess of any service limitation expressly set forth below. Except to the extent that such service limitations are set forth below, the general descriptions below of ACO Covered Services do not limit the Contractor's obligation to provide all Medically Necessary services.

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
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, for pain relief or anesthesia.	✓	✓	✓
Acute Inpatient Hospital –all inpatient services such as daily physician intervention, surgery, obstetrics, radiology, laboratory, and other diagnostic and treatment procedures. Coverage of acute inpatient hospital services shall include Administratively Necessary Days. Administratively Necessary Day shall be defined as a day of Acute Inpatient Hospitalization on which an Enrollee's care needs can be provided in a setting other than an Acute Inpatient Hospital and on which an Enrollee is clinically ready for discharge.	✓	✓	✓
Ambulatory Surgery/Outpatient Hospital Care - outpatient surgical, related diagnostic, medical and dental services.	✓	✓	✓
Audiologist – audiologist exams and evaluations. See related hearing aid services.	✓	✓	✓
Behavioral Health Services – see **Appendix C, Exhibit 3**.	✓	✓	✓
Breast Pumps – to expectant and new birthing parents as specifically prescribed by their attending physician, consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014, including but not limited to double electric breast pumps one per birth or as medically necessary.	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
Certain COVID-19 Specimen Collection and Testing – Specimen collection codes G2023 and G2024 billed with modifier CG, used when provider 1) has a qualified ordering clinician present at the specimen collection site available to order medically necessary COVID-19 diagnostic tests; and 2) ensures the test results are provided to the patient (along with any initial follow-up counseling, as appropriate), either directly or through the patient's ordering clinician.	✓	✓	✓
Chiropractic Services – The Contractor is responsible for providing chiropractic manipulative treatment, office visits, and radiology services for all Enrollees. The Contractor may establish a per Enrollee per Contract Year service limit of 20 office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments.	✓	✓	✓
Chronic, Rehabilitation Hospital or Nursing Facility Services – services, for all levels of care, including for eligible Enrollees under the age of 22 in accordance with applicable state requirements, provided at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, 100 days per Contract Year per Enrollee The 100-day limitation shall not apply to Enrollees receiving Hospice services and the Contractor may not request disenrollment of Enrollees receiving Hospice services based on the length of time in a nursing facility. The Contractor shall use the following MassHealth admission/coverage criteria for admission into a chronic hospital, rehabilitation hospital and nursing facility, and may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts such 100-day limitation described above. For the applicable criteria, see 130 CMR 456.408, 456.409, 456.410 and 435.408, 435.409 and 435.410 (rehabilitation hospitals). In addition, for Enrollees under the age of 22, the Contractor shall ensure that its contracted nursing facilities comply with the relevant provisions of 105 CMR 150.000, et seq. The Contractor must ensure that its contracted nursing facilities establish and follow a written policy regarding its bed-hold period, consistent with the MassHealth bed-hold policy. For applicable criteria, see 130 CMR 456.425. For clarification purposes, an Enrollee's stay while recovering from COVID-19 in a nursing facility or chronic or rehabilitation hospital, or any combination thereof, shall count towards the 100-day per Contract Year per Enrollee coverage	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
described in this section; provided, however for an Enrollee's stays in a Commonwealth-designated COVID-19 nursing facility, see non-ACO Covered Services in Exhibit 2 below.			
Dental - Emergency related dental services as described under Emergency Services in **Appendix C, Exhibit 1** and oral surgery which is Medically Necessary to treat a medical condition performed in any place of service, including but not limited to an outpatient setting, as described in Ambulatory Surgery/Outpatient Hospital Care in **Appendix C, Exhibit 1** as well as a clinic or office settings.	✓	✓	✓
Diabetes Self-Management Training – diabetes self-management training and education services furnished to an individual with pre-diabetes or diabetes by a physician or certain accredited mid-level providers (e.g., registered nurses, physician assistants, nurse practitioners, and licensed dieticians).	✓	✓	✓
Dialysis – laboratory; prescribed drugs; tubing change; adapter change; and training related to hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis.	✓	✓	✓
Durable Medical Equipment and Medical/Surgical Supplies – **1) Durable Medical Equipment** - products that: (a) are fabricated primarily and customarily to fulfill a medical purpose; (b) are generally not useful in the absence of illness or injury; (c) can withstand repeated use over an extended period of time; and (d) are appropriate for home use. Includes but not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, & rentals), walkers, commodes, special beds, monitoring equipment, and the rental of Personal Emergency Response Systems (PERS). **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 including, but not limited to, items such as urinary catheters, wound dressings, and diapers.	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services – Children, adolescents and young adults who are under 21 years old and are enrolled in MassHealth Standard and CommonHealth are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including Medically Necessary services that are listed in 42 U.S.C. 1396d(a) and (r) and discovered as a result of a medical screening.	✓		
Early Intervention –child visits, center-based individual visits, community child group, early intervention-only child group, and parent-focused group sessions; evaluation/assessments; and intake/screenings. The Contractor may establish a service limit restricting Early Intervention Services to Enrollees aged 3 or under.	✓	✓	
Emergency Services – covered inpatient and outpatient services, including Behavioral Health Services, which are furnished to an Enrollee by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.	✓	✓	✓
Family Planning – family planning medical services, family planning counseling services, follow-up health care, outreach, and community education. Under Federal law, an Enrollee may obtain family planning services from any MassHealth provider of family planning services without the Contractor's authorization.	✓	✓	✓
Fluoride Varnish – Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses) may apply Fluoride Varnish to eligible MassHealth Enrollees under age 21, during a pediatric preventive care visit. This service is primarily intended for children 0-6 but may be covered up to age 21.	✓	✓	
Hearing Aids – The Contractor is responsible for providing and dispensing hearing aids; ear molds; ear impressions; batteries; accessories; aid and instruction in the use, care, and maintenance of the hearing aid; and loan of a hearing aid to the Enrollee, when necessary.	✓	✓	✓
Home Health Services – skilled and supportive care services provided in the member's home to meet skilled care needs and associated activities of daily living to allow the member to safely stay in their home. Available services include skilled nursing, medication administration, home health aide, and occupational, physical, and speech/language therapy. See CMR 403.000 and MassHealth Home Health Agency Bulletin 54 (June 2019).	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
Hospice – a package of services designed to meet the needs of terminally ill patients such as nursing; medical social services; physician; counseling; physical, occupational and speech language therapy; homemaker/home health aide services; medical supplies, drugs and durable medical equipment and supplies, short term general inpatient care, short term respite care, and room and board in a nursing facility provided, however, that the 100 day limitation on institutional care services shall not apply to an Enrollee receiving Hospice services. Hospice services covered by the Contractor shall include room and board in a nursing facility pursuant to 130 CMR 437.424(B). Hospice is an all-inclusive benefit. The Enrollee has to elect the Hospice benefit and, by electing the Hospice benefit, the Enrollee waives their right to the otherwise independent services that are for the Enrollee included as a part of the Hospice benefit. If an Enrollee elects Hospice, then the Enrollee waives their rights for the duration of the election of hospice care for any services related to the treatment of the terminal condition for which hospice care was elected or that are equivalent to hospice care. However, Enrollees under age 21 who have elected the Hospice benefit shall have coverage for curative treatment and all Medically Necessary ACO and Non-ACO Covered Services for MassHealth Standard and CommonHealth Enrollees.	✓	✓	✓
Infertility – Diagnosis of infertility and treatment of an underlying medical condition.	✓	✓	✓
Laboratory – all services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Enrollees. All laboratories performing services under this Contract shall meet the credentialing requirements set forth in **Section 2.9.H**, including all medically necessary vaccines not covered by the Commonwealth of Massachusetts Department of Public Health.	✓	✓	✓
MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids – a service that provides targeted case management services for high risk individuals under age 21 with medical complexity. MassHealth CARES for Kids provides comprehensive, high-touch care coordination for children and their families. This service is provided in certain primary care or specialized settings where medically complex individuals under age 21 receive medical care. MassHealth CARES for Kids providers will serve as lead entities to coordinate	✓		

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
prompt and individualized care across the health, educational, state agency, and social service systems.			
Medical Nutritional Therapy – nutritional, diagnostic, therapy and counseling services for the purpose of a medical condition that are furnished by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited mid-level providers (e.g., registered nurses, physician assistants, and nurse practitioners).	✓	✓	✓
Orthotics – braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. See Subchapter 6 of the Orthotics Manual.	✓	✓	✓
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.	✓	✓	✓
Pharmacy – The Contractor is responsible for providing prescription, over-the-counter drugs, and Non-Drug Pharmacy Products as described below. **1) Prescription Drugs:** prescription drugs that are approved by the U.S. Food and Drug Administration. The Contractor may limit coverage to those drugs manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. §1396r-8. **2) Over-the-Counter Drugs:** The Contractor may limit coverage to those drugs manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C.§1396r-8. Except with regard to insulin, the Contractor also may limit over-the-counter drugs for Enrollees aged 21 and over to those necessary for the life and safety of the Enrollee. **3) Non-Drug Pharmacy Products**: non-drug pharmacy products as listed in the MassHealth Non-Drug Product List	✓	✓	✓
Physician (primary and specialty) – all medical, developmental pediatrician, psychiatry, radiological, laboratory, anesthesia and surgical services, including those services provided by nurse practitioners serving as primary care providers and services provided by nurse midwives.	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
Podiatry – The Contractor is responsible for providing services as certified by a physician, including medical, radiological, surgical, and laboratory care. For restrictions regarding coverage of orthotics, see the "Orthotics" service description above.	✓	✓	✓
Preventive Pediatric Health Screening and Diagnostic Services - children, adolescents and young adults who are under 21 years old and are enrolled in the MassHealth Basic, Essential or Family Assistance Plan are entitled to Preventive Pediatric Healthcare Screening and Diagnosis Services as outlined in 130 CMR 450.150.		✓	
Prosthetic Services and Devices – evaluation, fabrication, fitting, and the provision of a prosthesis. For individuals over age 21, certain limitations apply. See Subchapter 6 of the Prosthetics Manual	✓	✓	✓
Radiology and Diagnostic Tests – X-rays, portable X-rays, magnetic resonance imagery (MRI) and other radiological and diagnostic services, including those radiation or oncology services performed at radiation oncology centers (ROCs) which are independent of an acute outpatient hospital or physician service.	✓	✓	✓
Remote Patient Monitoring (COVID-19 RPM) - bundled services to facilitate home monitoring of Enrollees with confirmed or suspected COVID-19 who do not require emergency department or hospital level of care but require continued close monitoring. The COVID-19 RPM bundle includes all medically necessary clinical services required to facilitate seven days of close, in-home, monitoring of members with confirmed or suspected COVID-19. Details around MassHealth's coverage of the RPM bundle can be found in All Provider Bulletin 294, as may be updated from time to time. The Contractor must cover the RPM bundle of services in the method and manner specified in All Provider Bulletin 294, as may be updated from time to time, when such services are delivered as Medicaid services. The Contractor may determine their own rate of payment for the RPM bundle of services.	✓	✓	✓
School Based Health Center Services – all ACO Covered Services set forth in this Appendix C delivered in School Based Health Centers (SBHCs).	✓	✓	
Therapy – individual treatment, (including the design, fabrication, and fitting of an orthotic, prosthetic, or other assistive technology device); comprehensive evaluation; and group therapy.	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
1) **Physical:** evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems. 2) **Occupational:** evaluation and treatment designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. 3) **Speech and Hearing:** evaluation and treatment of speech language, voice, hearing, and fluency 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 410.447 and pharmacotherapy treatment, including nicotine replacement therapy (NRT).	✓	✓	✓
Transportation (emergent) – ambulance (air and land) transport that generally is not scheduled, but is needed on an Emergency basis, including Specialty Care Transport that is ambulance transport of a critically injured or ill Enrollee from one facility to another, requiring care that is beyond the scope of a paramedic.	✓	✓	✓
Transportation (non-emergent, to out-of-state location) – ambulance and other common carriers that generally are pre-arranged to transport an Enrollee to a service that is located outside a 50-mile radius of the Massachusetts border.	✓		✓
Urgent Care Clinic Services – ACO Covered Services set forth in this Appendix C provided by an urgent care clinic consistent with 130 CMR 455.000 and Section 39 of Ch. 260 of the Acts of 2020.	✓	✓	✓
Vaccine Counseling Services	✓	✓	✓
Vision Care (medical component) – eye examinations (a) once per 12-month period for Enrollees under the age of 21 and (b) once per 24-month period for Enrollees 21 and over, and, for all Enrollees, whenever Medically Necessary; vision training; ocular prosthesis; contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus; and bandage lenses.	✓	✓	✓
Wigs – as prescribed by a physician related to a medical condition.	✓	✓	✓

Appendix C

Exhibit 2: Non-ACO Covered Services

✓ Denotes a Non-ACO Covered Service (wrap service)

The Contractor need not provide, but shall coordinate, for each Enrollee the delivery of all MassHealth services (see 130 CMR 400.000 through 499.000) for which such Enrollee is eligible (see 130 CMR 450.105) but which are not currently ACO Covered Services. Coordination of such services shall include, but not be limited to, informing the Enrollee of the availability of such services and the processes for accessing those services. The general list and descriptions, below, of MassHealth services that are not ACO Covered Services do not constitute a limitation on the Contractor's obligation to coordinate all such services for each Enrollee eligible to receive those services.

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Abortion - includes, in addition to the procedure itself, pre-operative evaluation and examination; pre-operative counseling; laboratory services, including pregnancy testing, blood type, and Rh factor; Rh, (D) immune globulin (human); anesthesia (general or local); echography; and post-operative (follow-up) care. Abortion does not constitute a family planning service. The procedure itself is federally funded only in the following situations: (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. Such services may be provided in a physician's office, clinic, or hospital, subject to limitations imposed by applicable law and administrative and billing regulations.	✓	✓	✓
Adult Dentures – full and partial dentures, and repairs to said dentures, for adults ages 21 and over.	✓	✓	✓
Adult Day Health – services ordered by a physician and delivered to an Enrollee in a community-based program setting that is open at least Monday through Friday for eight hours per day and include: nursing and healthcare oversight, therapy, assistance with Activities of Daily Living (ADL), nutritional and dietary, counseling activities and case management. Services provided are based upon an individual plan of care.	✓		

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
Transportation to and from the Adult Day Health program is arranged and reimbursed by the Adult Day Health program. In order to be eligible for Adult Day Health Services, the Enrollee must be at least 18 years of age or older and require assistance with at least one (1) ADL or one (1) skilled service and meet the eligibility criteria outlined in 130 CMR 404.407.			
Adult Foster Care - services ordered by a physician and delivered to an Enrollee in a home environment that meets the qualified setting as described in 130 CMR 408.435 Services are based upon an individual plan of care and include assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other personal care as needed, nursing services and oversight, and care management. Assistance with ADLs, IADLs and other personal care is provided by a qualified caregiver that lives with the Enrollee in the home environment. Nursing services and oversight and care management are provided by a multidisciplinary team. In order to be eligible for Adult Foster Care services, the Enrollee must be at least 16 years of age or older an require assistance with at least one (1) ADL and meet the eligibility criteria outlined in 130 CMR 408.417.	✓		
Chapter 766 – home assessments and participation in team meetings.	✓	✓	
Chronic, Rehabilitation Hospital, or Nursing Facility Services – Both 1. Services provided at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, over 100 days per Contract Year per Enrollee; provided, however, that (A) for Enrollees receiving Hospice services, the Contractor shall cover skilled nursing facility services without limitation, and (B) for Enrollees in Family Assistance such coverage is limited to six months consistent with MassHealth policy; and 2. Any stay of any duration in a Commonwealth-designated COVID-19 nursing facility.	✓	✓	
Day Habilitation – services provided in a community based day program setting that is open at least Monday through Friday for six hours per day and includes daily programming based on activities and therapies necessary to meet individual goals and	✓		

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
objectives. Goals and objectives are outlined on a day habilitation service plan and are designed to help an Enrollee reach his/her optimal level of physical, cognitive, psychosocial and occupational capabilities. In order to be eligible for Day Habilitation services, the Enrollee must be at least 18 years of age or older; have a diagnosis of mental retardation and/or developmental disability; and meet the eligibility criteria outlined in 130 CMR 419.434.			
Dental - preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health for children and adults as described in 130 CMR 420.000.	✓	✓	✓
Digital Therapy Products – Digital therapy products designated by EOHHS. Such digital therapy products, even though such products are Non-ACO 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-ACO Covered Services, must be processed through Contractor's on-line pharmacy claims processing system and be paid to the pharmacy at $0 pay, with $0 cost share for members.	✓	✓	✓
Group Adult Foster Care - services ordered by a physician delivered to an Enrollee in a group housing residential setting such as assisted living, elderly, subsidized or supportive housing. Group Adult Foster Care services are based upon an individual plan of care and include: assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other personal care as needed, nursing services and oversight and care management. Assistance with ADLs, IADLs and other personal care is provided by a direct care worker that is employed or contracted by the Group Adult Foster Care Provider, Nursing services and oversight and care management are provided by a multidisciplinary team. In order to be eligible for Group Adult Foster Care services, the Enrollee must be at least 22 years of age or older and require assistance with at least one (1) ADL.	✓		

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
Isolation and Recovery Site Services – services received by an Enrollee in an Isolation and Recovery site that are paid for by EOHHS using the payment methodologies described in Administrative Bulletin AB 20-30 or as set forth in the Acute Hospital RFA.	✓	✓	✓
Keep Teens Healthy - services provided pursuant to EOHHS's "Keep Teens Healthy" provider agreement.	✓	✓	
Personal Care Attendant – physical assistance with Activities of Daily Living (ADLs) such as: bathing, dressing/grooming, eating, mobility, toileting, medication administration, and passive range of motion exercise for Enrollees who have a chronic or permanent disability requiring physical assistance with two (2) or more ADLs. If an Enrollee is clinically eligible for PCA, an Enrollee may also receive assistance with Instrumental Activities of Daily Living (IADLs), including household management tasks, meal preparation, and transportation to medical providers.	✓		
Private Duty Nursing/Continuous Skilled Nursing – a nursing visit of more than two continuous hours of nursing services. This service can be provided by a home health agency, continuous skilled nursing agency, or Independent Nurse.	✓		
Transitional Support Services (TSS) for Substance Use Disorders (Level 3.1) – 24- hour short term intensive case management and psycho-educational residential programming with nursing available for members with substance use disorders who have recently been detoxified or stabilized and require additional transitional stabilization prior to placement in a residential or community based program. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.	✓	✓	✓
Transportation (non-emergent, to in-state location or location within 50 miles of the Massachusetts border) - ambulance (land), chair car, taxi, and common carriers that generally are pre-arranged to transport an Enrollee to a covered service that is located in-state or within a 50-mile radius of the Massachusetts border.	✓		✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
Vision Care (non-medical component) - prescription and dispensing of ophthalmic materials, including eyeglasses and other visual aids, excluding contacts.	✓	✓	✓

Appendix C
Exhibit 3: ACO Covered Behavioral Health Services
✓ Denotes a covered service

	Coverage Types		
Service	**ACO MassHealth Standard & CommonHealth Enrollees**	**ACO MassHealth Family Assistance Enrollees**	**CarePlus**
Inpatient Services - 24-hour services, delivered in a licensed or state-operated hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both. This service does not include continuing inpatient psychiatric care delivered at a facility that provides such services, as further specified by EOHHS. **(See details below)**			
1. Inpatient Mental Health Services - hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.	✓	✓	✓
2. Inpatient Substance Use Disorder Services (Level 4) - Intensive inpatient services provided in a hospital setting, able to treat Enrollees with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credentialed physician and other appropriate credentialed treatment professionals with the full resources of a general acute care or psychiatric hospital available.	✓	✓	✓
3. Observation/Holding Beds - hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Enrollees.	✓	✓	✓
4. Administratively Necessary Day (AND) Services - a day(s) of inpatient hospitalization provided to Enrollees when said Enrollees are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.	✓	✓	✓
Diversionary Services - those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility. **(See detailed services below)**			
24-Hour Diversionary Services:			

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
a. 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 Enrollees who do not require Inpatient Services.	✓	✓	✓
b. **Community-Based Acute Treatment for Children and Adolescents (CBAT)** – mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.	✓	✓	
c. Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7) – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Withdrawal management services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; induction to FDA approved medications for addictions when appropriate, individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. 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.	✓	✓	✓
d. Clinical Support Services 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, including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive psycho education and counseling, outreach to families and significant others, linkage to medications for addiction therapy, connection to primary care and community supports and aftercare planning for individuals	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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. Pregnant women receive coordination of their obstetrical care.			
e. Transitional Care Unit (TCU) – A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies**.**	✓	✓	
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)			
a. Adult Residential Rehabilitation Services 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. Residential programs licensed and approved to serve pregnant and post-partum women provide assessment and management of gynecological and/or obstetric and other prenatal needs, as well as treatment plans addressing parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
b. Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour residential environment for families in which a parent has a substance use disorder and either is pregnant, has custody of at least one child or has a physical reunification plan with at least one child within 30 days of admission. Scheduled, goal-oriented rehabilitative services intended to support parents and children are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal and parenting skills necessary to lead an alcohol and/or drug-free lifestyle and support family reunification and stability. Enrollees receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities.	✓	✓	✓
c. Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour developmentally appropriate residential environment designed specifically for either Transitional Age Youth ages 16-21 or Young Adults ages 18-25 that provides a structured and comprehensive rehabilitative environment for 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. Enrollees 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.	✓	✓	✓
d. Youth Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour developmentally appropriate residential environment with enhanced staffing and support designed specifically for youth ages 13-17 that provides a structured and comprehensive rehabilitative environment for 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	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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.			
e. Co-Occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour, safe, structured environment, located in the community, which supports Enrollee's recovery from addiction and moderate to severe mental health conditions while reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate. Programs will ensure that Members have access to prescribers of psychiatric and addiction medications.	✓	✓	✓
Non-24-Hour Diversionary Services			
a. **Community Support Program (CSP)** and Specialized CSP - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Enrollees with a long standing history of a psychiatric or substance use disorder and to their families, or to Enrollees who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee. Specialized CSP programs serve populations with particular needs. **Specialized CSP Programs:** **1. CSP for Justice Involved –** a Specialized CSP service to address the health-related social needs of members with Justice Involvement and have a barrier to accessing or	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
consistently utilizing medical and behavioral health services, as defined by EOHHS. CSP-JI includes behavioral health and community tenure sustainment supports. 2. **CSP for Homeless Individuals –** a Specialized CSP service to address the health-related social needs of members who (1) are experiencing Homelessness and are frequent users of acute health MassHealth services, as defined by EOHHS, or (2) are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development. 3. **CSP – Tenancy Preservation Program -** a Specialized CSP service to address the health-related social needs of members who are At Risk of Homelessness and facing Eviction as a result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation. CSP-TPP services have the primary goal of the CSP-TPP is preserve the tenancy and the secondary goals are to put in place services that address those issues that put the member's housing in jeopardy to ensure that the member's housing remains stable.			
b. Partial Hospitalization (PHP) – an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available five to seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.	✓	✓	✓
c. Psychiatric Day Treatment - services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs 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 does not need 24-hour hospitalization.	✓	✓	✓
d. 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	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24-hour monitoring.			
e. 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.	✓	✓	✓
f. Recovery Coaching - a non-clinical service provided by individuals currently in recovery from a substance use disorder who have been certified as Recovery Coaches. Eligible Enrollees will be connected with Recovery Coaches at critical junctures in the Enrollees' treatment and recovery. 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, facilitate initiation and engagement to treatment and serve as a guide and motivating factor for the Enrollee to maintain recovery and community tenure.	✓	✓	✓
g. Recovery Support Navigators - a specialized care coordination service intended to engage Enrollees with Substance Use Disorder in accessing and continuing Substance Use Disorder treatment. RSNs may be located in a variety of Substance Use Disorder treatment environments, doing outreach and building relationships with individuals in programs, including withdrawal management and step-down services. If an Enrollee accepts RSN services upon leaving a Substance Use Disorder treatment program, the RSN will work with the individual on accessing appropriate treatment and staying motivated for treatment and recovery.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
h. 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 Enrollees 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.	✓	✓	✓
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. The services may be provided at an Enrollee's home or school. **(See detailed services below)**			
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.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
k. Assessment for Safe and Appropriate Placement (ASAP) - an assessment, required by MGL 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of DCF and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a DCF designated ASAP provider.	✓	✓	
l. Collateral Contact – a communication of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of an Enrollee under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.	✓	✓	
m. 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.	✓	✓	✓
n. Opioid Treatment Services — supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses withdrawal treatment and maintenance treatment	✓	✓	✓
o. Ambulatory Withdrawal Management (Level 2WM) - outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Withdrawal Management is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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.			
p. 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.	✓	✓	✓
q. Special Education Psychological Testing - psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass Gen. Law 71B, and which shall be utilized toward the development of an Individualized Educational Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.	✓	✓	
r. Applied Behavioral Analysis for members under 21 years of age (ABA Services) – A MassHealth service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning. See 101 CMR 358.00.	✓	✓	
s. Early Intensive Behavioral Intervention (EIBI) - provided to children under three years of age who have a diagnosis of autism spectrum disorder (ASD) and meet clinical eligibility criteria. Such services shall be provided only by DPH-approved, Early Intensive Behavioral Intervention Service Providers.	✓	✓	

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
t. Preventative Behavioral Health Services - short-term interventions in supportive group, individual, or family settings, recommended by a physician or other licensed practitioner, practicing within their scope of licensure, that cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns, which may prevent the development of behavioral health conditions for members who are under 21 years old who have a positive behavioral health screen (or, in the case of an infant, a caregiver with a positive post-partum depression screening), even if the member does not meet criteria for behavioral health diagnosis. Preventive behavioral health services are available in group sessions when delivered in community-based outpatient settings, and in individual, family, and group sessions when provided by a behavioral health clinician practicing in an integrated pediatric primary care setting.	✓	✓	
Intensive Home or Community-Based Services for Youth – mental health and substance use disorder services provided to Enrollees in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service. **(See detailed services below)**			
a. Family Support and Training: a service provided to the parent /caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home and other community settings. Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning. Services may include education, assistance in navigating the child serving systems; fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources, support, coaching, and training for the parent/caregiver.	✓		
b. Intensive Care Coordination: a service that provides targeted case management services to individuals under 21 with a Serious Emotional Disturbance including individuals with co-occurring conditions. This service includes assessment, development of an individualized	✓		

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
care plan, referral and related activities to implement the care plan and monitoring of the care plan.			
c. In-Home Behavioral Services – this service usually includes a combination of behavior management therapy and behavior management monitoring, as follows: **C1. Behavior Management Therapy**: This service includes assessment, development of the behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance. This service addresses challenging behaviors which interfere with the child's successful functioning. The Behavior management therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and level of intervention required. Phone contact and consultation may be provided as part of the intervention. **C2. Behavior Management Monitoring**. This service includes implementation of the behavior plan, monitoring the child's behavior, reinforcing implementation of the plan by parents or other caregivers and reporting to the behavior management therapist on implementation of the plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.	✓		
d. In-Home Therapy Services. This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows: **D1**. The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the child's mental health needs including improving the family's ability to provide effective support for the child to promote healthy functioning of the child within the family. The clinician develops a treatment plan and, using established	✓	✓	

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals. **D2**. Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.			
e. Therapeutic Mentoring Services: This service provides a structured, one-to-one mentoring relationship between a therapeutic mentor and a child or adolescent for the purpose of addressing daily living, social and communication needs. Each child or adolescent will have goals and objectives that are designed to support age-appropriate social functioning or ameliorate deficits in the child or adolescent's age-appropriate social functioning. These goals and objectives are developed by the child or adolescent, as appropriate, and his/her treatment team and are incorporated into the treatment plan. The service includes supporting, coaching and training the child or adolescent in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities. The therapeutic mentor works with the child or adolescent in such settings as their home, school or social or recreational activities.	✓		
Crisis Services – Crisis services are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. **(See detailed services below)**			

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
1. Adult Mobile Crisis Intervention (AMCI) Encounter – each 24-hour period an individual is receiving AMCI Services. Each AMCI 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.	✓	✓	✓
2. Youth Mobile Crisis Intervention (YMCI) –a short-term mobile, on-site, face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, seven days a week.	✓	✓	
3. Emergency Department-based Crisis Intervention Mental Health Services: Behavioral health crisis interventions include the crisis evaluation, stabilization interventions, and disposition coordination activities for members presenting to the ED in a behavioral health crisis. Elements of crisis evaluations include: **a. Crisis Evaluation**: Behavioral Health crisis assessment by a qualified behavioral health professional to individuals within 60 minutes of time of the member's readiness to receive such an assessment. Qualified behavioral health professionals include: qualified behavioral health professional, a psychiatrist, and other master's and bachelor's-level clinicians and staff sufficient to meet the needs of members served which may include certified peer specialists and recovery coaches.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
b. Crisis Stabilization Interventions: Observation, treatment, and support to individuals experiencing a behavioral health crisis. **c. Discharge Planning and Care Coordination**: A disposition plan that includes discharge planning to identify and secure an appropriate level of care and goals for that level of care			
Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type.			
1. Electro-Convulsive Therapy (ECT) - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.	✓	✓	✓
2. Repetitive Transcranial Magnetic Stimulation (rTMS) - a noninvasive form of neurostimulation in which rapidly changing magnetic fields are applied to the surface of the scalp through a copper wire coil connected to a magnetic stimulator. The therapeutic service is used to treat depression that has not responded to standard treatment such as medications and psychotherapy.	✓	✓	✓
3. Specialing - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.	✓	✓	✓

APPENDIX C
Exhibit 4: MassHealth Excluded Services – All Coverage Types

Except as otherwise noted or determined Medically Necessary by EOHHS, the following services are not covered under MassHealth and as such are not covered by the Contractor.

1. Cosmetic surgery, except as determined by the Contractor to be necessary for:
   a. correction or repair of damage following an injury or illness;
   b. mammoplasty following a mastectomy; or
   c. any other medical necessity as determined by the Contractor.

   All such services determined by the Contractor to be Medically Necessary shall constitute an ACO Covered Service under the Contract.

2. Treatment for infertility, including in-vitro fertilization and gamete intra-fallopian tube (GIFT) procedures.

3. Experimental treatment.

4. Personal comfort items including air conditioners, radios, telephones, and televisions (effective upon promulgation by EOHHS of regulations at 130 CMR regarding non-coverage of air conditioners).

5. Services not otherwise covered by MassHealth, except as determined by the Contractor to be Medically Necessary for MassHealth Standard or MassHealth CommonHealth Enrollees under age 21. In accordance with EPSDT requirements, such services constitute an ACO Covered Service under the Contract.

6. A service or supply which is not provided by or at the direction of a Network Provider, except for:
   a. Emergency Services as defined in **Section 1** of this Contract;
   b. Family Planning Services; and

7. Non-covered laboratory services as specified in 130 CMR 401.411.

APPENDIX D
PAYMENT

EXHIBIT 1
BASE CAPITATION RATES AND ADD-ONS
Contract Year 1

Listed below are the Per Member Per Month (PMPM) Base Capitation Rates for Contract Year 1 (Contract Operational Start Date through December 31, 2023) (also referred to as Rate Year 2023 or RY23), subject to state appropriation and all necessary federal approvals;

Base Capitation Rates do not include EOHHS adjustments described in **Section 4.3** of the Contract.

In addition to the Base Capitation Rates tables below, additional tables include the add-on for the Contract Year, for ABA Services as described in **Section 4.5.E**, for High Cost Drugs as described in **Section 4.5.F** and for SUD Risk Sharing Services as described in **Section 4.5.G**. The add-on for High Cost Drugs, ABA Services and SUD Risk Sharing Services are the same for all Regions and will be added to the Risk Adjusted Capitation Rates as defined in **Section 4.2.E**.

ACPP Base Capitation Rates / RC I Adult			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$599.98	$40.54	$640.52
Greater Boston	$622.64	$42.00	$664.64
Southern	$640.21	$41.87	$682.08
Central	$590.97	$40.32	$631.29
Western	$543.18	$38.79	$581.97

ACPP Base Capitation Rates / RC I Child			
Effective Contract Operational Start Date– December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$228.97	$28.71	$257.68
Greater Boston	$235.52	$30.06	$265.58
Southern	$238.29	$29.66	$267.95
Central	$240.18	$28.93	$269.11
Western	$243.85	$29.60	$273.45

ACPP Base Capitation Rates / RC II Adult			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$2,119.56	$95.46	$2,215.02
Greater Boston	$2,290.68	$103.96	$2,394.64
Southern	$2,196.87	$96.79	$2,293.66
Central	$2,070.99	$92.82	$2,163.81
Western	$1,783.06	$82.28	$1,865.34

ACPP Base Capitation Rates / RC II Child			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,235.40	$90.47	$1,325.87
Greater Boston	$1,234.48	$98.15	$1,332.63
Southern	$1,148.31	$88.63	$1,236.94
Central	$1,048.49	$80.83	$1,129.32
Western	$865.42	$69.34	$934.76

ACPP Base Capitation Rates / RC IX			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$627.73	$41.84	$669.57
Greater Boston	$625.52	$42.47	$667.99
Southern	$699.97	$44.91	$744.88
Central	$661.00	$42.93	$703.93
Western	$604.52	$41.43	$645.95

ACPP Base Capitation Rates / RC X			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$2,148.41	$95.83	$2,244.24
Greater Boston	$2,279.40	$102.56	$2,381.96
Southern	$1,992.51	$90.67	$2,083.18
Central	$1,886.64	$86.16	$1,972.80
Western	$1,597.87	$75.84	$1,673.71

High Cost Drug Add-On to Risk Adjusted Capitation Rates
Effective Contract Operational Start Date – December 31, 2023 (RY23)

High Cost Drug Add-On to Risk Adjusted Capitation Rates PMPM					
REGION	**Northern**	**Greater Boston**	**Southern**	**Central**	**Western**
RC I Adult	**$5.77**	**$2.82**	**$1.55**	**$5.32**	**$0.26**
RC I Child	**$6.20**	**$6.11**	**$3.90**	**$2.67**	**$2.72**
RC II Adult	**$17.69**	**$9.99**	**$16.66**	**$64.54**	**$21.08**
RC II Child	**$67.22**	**$138.46**	**$21.89**	**$117.82**	**$30.11**
RC IX	**$5.48**	**$6.87**	**$4.22**	**$14.18**	**$4.00**
RC X	**$1.76**	**$2.47**	**$3.29**	**$0.90**	**$0.91**

ABA Add-On to Risk Adjusted Capitation Rates
Effective Contract Operational Start Date – December 31, 2023 (RY23)

ABA Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	**$11.97**
RC-II Child	**$282.24**

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates
Effective Contract Operational Start Date – December 31, 2023 (RY23)

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Adult	**$6.09**
RC-I Child	**$0.30**
RC-II Adult	**$17.76**
RC-II Child	**$0.47**
RC-IX	**$13.28**
RC-X	**$166.73**

EXHIBIT 2
ADJUSTMENTS OR ADDITIONS TO PAYMENTS
Contract Year 1

The table shows the admission-level stop-loss attachment point for the Contract Year as described in **Section 4.3.B**.

Admission Level Stop-Loss Attachment Point
$150,000

EXHIBIT 3
RISK SHARING ARRANGEMENTS
Contract Year 1

Market-Wide Risk Sharing Arrangement (Market Corridor) (Section 4.5.C)

If the Market Corridor expenditures, as determined by EOHHS in accordance with **Section 4.5.C.3**, are greater than or less than the Market Corridor revenue, as determined by EOHHS in accordance with **Section 4.5.C.2**, the Contractor and EOHHS shall share the resulting loss or gain as follows:

1. **Gain on the Market Corridor**

Gain	MassHealth Share	Market Share
Absolute value of the Gain less than or equal to 0.75% of the Market Corridor Revenue	0%	100%
Absolute value of the Gain greater than 0.75% of the Market Corridor Revenue	95%	5%

2. **Loss on the Market Corridor**

Loss	MassHealth Share	Market Share
Absolute value of the Loss less than or equal to 0.75% of the Market Revenue	0%	100%
Absolute value of the Gain greater than 0.75% of the Market Revenue	95%	5%

Contract-Wide Risk Sharing Arrangement ("Plan Corridor") (Section 4.5.D)

If the Contractor's Plan Corridor expenditures, as determined by EOHHS in accordance with **Section 4.5.D.3**, is greater than or less than the Contractor's Plan Corridor revenue as determined by EOHHS in accordance with **Section 4.5.D.2**, the Contractor and EOHHS shall share the resulting loss or gain as follows:

1. **Gain on the Plan Corridor**

Gain	MassHealth Share	Contractor Share
Absolute value of the Gain less than or equal to 5% of Plan Corridor Revenue	0%	100%
Absolute value of the Gain greater than 5% of the Plan Corridor Revenue	95%	5%

2. **Loss on the Plan Corridor**

Loss	MassHealth Share	Contractor Share
Absolute value of the Loss less than or equal to 5% of Plan Corridor Revenue	0%	100%
Absolute value of the Loss greater than 5% of the Plan Corridor Revenue	95%	5%

ABA Services Risk Sharing Arrangement (Section 4.5.E)

If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.E.2**, is greater than or less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.E.3**, then the Contractor shall be considered to have experienced a gain or a loss with respect to ABA Services for the Contract Year. EOHHS and the Contractor shall share such gain or loss as follows:

1. **Gain on the ABA Add-On to the Risk Adjusted Capitation Rate**

Gain	MassHealth Share	Contractor Share
Gain up to $100,000	99%	1%
Gain of more than $100,000	100%	0%

2. **Loss on the ABA Add-On to the Risk Adjusted Capitation Rate**

Loss	MassHealth Share	Contractor Share
Loss up to $100,000	99%	1%
Loss of more than $100,000	100%	0%

High Cost Drug Add-On Risk Sharing Arrangement (Section 4.5.F)

1. **Gain on the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment**

   The amount of the Gain on the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual Non-HCV High Cost Drug expenditures for ACO Covered Services for the Contract Year, if such actual expenditures are less than the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year. The Gain shall be calculated in aggregate across all Regions and Rating Categories.

Gain	MassHealth Share	Contractor Share
Gain up to $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	99%	1%
Gain of more than $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	100%	0%

2. **Loss on the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment**

   The amount of the Loss on the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual Non-HCV High Cost Drug expenditures for ACO Covered Services for the Contract Year, if such actual expenditures are greater than the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year. The Loss shall be calculated in aggregate across all Regions and Rating Categories.

Loss	MassHealth Share	Contractor Share
Loss up to $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	99%	1%
Loss of more than $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	100%	0%

SUD Services Risk Sharing Arrangement (Section 4.5.G)

If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.G.2**, is greater than or less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.G.3**, then the Contractor shall be considered to have experienced a gain or a loss with respect to SUD Risk Sharing Services for the Contract Year. EOHHS and the Contractor shall share such gain or loss as follows:

1. **Gain on the SUD Risk Sharing Services Add-On to the Risk Adjusted Capitation Rate**

Gain	MassHealth Share	Contractor Share
Gain up to $100,000	99%	1%
Gain of more than $100,000	100%	0%

2. **Loss on the SUD Risk Sharing Services Add-On to the Risk Adjusted Capitation Rate**

Loss	MassHealth Share	Contractor Share
Loss up to $100,000	99%	1%
Loss of more than $100,000	100%	0%

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE
OF
HEALTH AND HUMAN SERVICES

MASSHEALTH DATA WAREHOUSE
PAID ENCOUNTER DATA SET REQUEST

Version 4.12

March 25, 2022

Revision History

Date	Revision	Name

Nov 2021 – Jan 2022	Clarifications/Updates include:
	• Acronym Table: Added ACPP, FFSE, ICO
	• Table of contents
	• Section 1.0 Introduction: Added clarification to encounter definition, uses for encounters, expectation for reporting medical costs, submission-rejection-resubmission cycle. Introduced list of files included in encounter submission, introduced a new encounter email address for question.
	• Segment 1.1 Data Requirements:
	  ○ Clarifications to paid vs. denied, zero paid claims, preventing multiple versions of claims / MH use of "last in chain", claim integrity, encounter submission timeliness, expectations for data completeness and validity for all fields.
	  ○ Removed redundant submission-rejection-resubmission cycle paragraph.
	• Section 2.0 Data Element Clarifications: Added "Record Type Submission Options and Explanations" reference table (including use cases to encourage better use of the "Replacement" Record Type); added further explanation of unique claim number/suffix requirement; added clarity to Dollar Amounts segment; clarified Record Indicator use, clarified diagnosis code requirements, decommissioned Record Indicator #3 and removed example #4; added clarity to Bundle Indicator examples as well as Former Claim Number and Suffix examples.
	• Section 2.0, 3.1 Provider File Data Set: Clarified requirement for plans to report MassHealth Provider Identification number in the "Medicaid Number" field of their Provider file pursuant to 42 CFR 438.602(b)(1).
	• Section 2.0 / 3.0 field requirements: Clarified requirement for recovery reporting through "Void Reason Code" field, ICD10-PCS reporting, 340b reporting through the "Submission Clarification Code"
	• Section 3.0 Encounter Data Set Elements with Record Layout:
	  ○ Updated MCE Names in "Org. Code" field and added clarity to descriptions in the fields: "Record Indicator", "Claim Category", "Primary Diagnosis", "Dispense As Written Indicator", "Paid Date", "Billed Charge", "Gross Payment Amount", "Copay", "Coinsurance", "Deductible", "Patient Pay Amount", "Net Payment", "New Member ID", "Service Category", "Allowable Amount", "Void Reason Code", "Surgical Procedure Code", "Total Charges", "Metric Qty"/"Unit of Measure", "Quantity", "Void Reason Code"
	  ○ Changed field name of Copay/Coinsurance to just Copay.
	  ○ Replaced datatype SN with N in all the monetary fields and "Quantity" field.
	  ○ Length for "Claim Number", "Former Claim Number" and "Service Category" fields were updated in the specs to reflect longer actual acceptable length. The following Fields are not required for retail pharmacy encounters ("R") and the "X" was removed: "Claim Type", "Service Class", "PCC Internal Provider ID", "Authorization Type", "Family Planning Indicator", "PCC Internal Provider ID Type", "Employment", "Auto Accident", "Other Accident", "Non-Covered charges", "Bundle Claim Number", "Bundle Claim Suffix", and "PCP Provider ID Address Location Code".
	  ○ Added clarity to descriptions in the fields "Provider ID", "Provider ID Type", "Provider ID Address Location Code", "Medicaid Number"
	  ○ Added clarity to Provider File Requirements, including reporting of "Medicaid Number" and "Provider Bundle ID" in examples.
	• Section 4.0 Error Handling:
	  ○ Added Error Code 75 "Codes on record are not in sequence" for gaps in Diagnosis Code and Surgical Procedure Code sequence.
	• Section 6.0 Media Requirements:
		Alla Kamenetsky
		Robert Sellers

Date	Revision	Name
	○ Name “Media Requirements" replaced with “Media Requirements / Encounter Claims Files Submission Requirements” ○ Added clarity to segments Manual Override File, Secure FTP Server, Sending Encounter Data, Receiving Error Reports. ○ CMS Internet Policy was removed. ○ Removed Segment “Monthly Financial Report” ○ Removed “Care Management Provider” file • Section 7 Standard Data Values: Reviewed and confirmed CMS value sets; updated CMS Place of Service Telehealth description; added clarity to Table D table name; for Table G, allow use of 00 value if Servicing Provider Type is not listed, provided additional guidance / links for choosing appropriate Unit of Measure (Table O). • Section 8.0 Quantity and Quality Edits, Reasonability and Validity Checks ○ Added expectation that fields must be valid as well as complete. ○ MassHealth adding checks for gaps in fields “Diagnosis Code” and “Surgical Procedure Code” sequence. ○ MassHealth clarification for validations for fields “Void Reason Code”, “Diagnosis code(s)”, “Servicing Provider Specialty”, “Bundle Indicator”, “Bundle Claim Number”, and “Bundle Claim Suffix”. ○ Enhanced readability and description consistency • Section 9.0 Appendices / Member File / Member Enrollment File Specifications ○ Removed references to Care Management file ○ Added completeness validity expectations for Race, Language and Ethnicity and Entity PIDSL. ○ Revised validation language for consistency ○ Revised headers for Table of Contents clarity • Standardized terminology throughout for consistency and readability • Updated MCE Names in “Org. Code” fields in all applicable sections. • All references to “PCC Internal Provider ID” changed to match “PCC Provider ID” for consistency, including in Revision History. • Added formatting and minor language changes throughout to improve readability • Updated language to reflect ICD10 and HIPAA EDI use cases	
05/03/2019	RENAMED: • Field #232 • old name - “FILLER” • new name - “Provider Payment”	Alla Kamenetsky
03/19/2019	Removed all the mentioning of potentially duplicate claims	Alla Kamenetsky
February, 2019	ADDED: • Field #232 “Filler” • Field #233 “Filler” • “Physician-Administered Drug Claim” Definition - Segment 2.0 “Data Elements Clarification” UPDATED: • Field # 11 “Medicare Code” – added value “Part D Only” • Table O “Unit of Measure” • Field 11 “Medicare Code” description • Table I – B1 “Service Category (Using the SCO reporting groups) “– added value “309 B – Pharmacy/Drug (Non-Part D)”	Alla Kamenetsky
12/15/2018	REMOVED: • Table N “Submission Clarification Code” • Section 1.1 – Removed requirements for Monthly Financial Reports ADDED:	Alla Kamenetsky

Date	Revision	Name
	• TABLE O - Unit Of Measure values • Field # 11 "Medicare Code" – added values (4 = Part A and D, 5 = Part B and D, 6 = Part A, B, and D) • Field #229 "Submission Clarification Code 2" • Field #230 "Submission Clarification Code 3" • Field #231 "Unit of Measure" • Submission Clarification Code description - Segment 2.0 "Data Elements Clarification" UPDATED: • TABLE C - Place of Service (HCFA 1500) Place of Service Codes for Professional Claims • TABLE M - POA Indicator Options and Definitions	
3/14/2018	• The length of all Address Location Code fields has been increased to 15 C • The length of MMIS Plan type (MBH only) has been increased to 5 C Additions and corrected typos: • SEGMENT "Data Requirements" ADDED: • "MCO claims where "From Service Date" is prior to 03/01/2018, the value of MCO PIDSL should be entered in "Entity PIDSL" field (#3)" ENCOUNTER • Field # 3: Entity PIDSL – added to the description "an ACO with which a PCC is contracted with" • Field # 13: Submission Clarification Code – is required on Pharmacy claim lines only • Field # 33: Type Of Bill – should be submitted on Hospital (H) and LTS (L) claims only • Field # 36: Quantity - the values should be submitted on claims of all types, but Pharmacy (R – Prescription Drug) • Field # 49: PCC Provider ID – should be submitted on claims of all types • Field # 92: PCC Provider ID Type - should be submitted on claims of all types PROVIDER To the list "The following fields are 100% required on all records" Added: • 19. Entity PIDSL • Field# 35: Entity PIDSL - description changed to: MCO/ACO providers: if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL in ENTITY_PIDSL if the provider is enrolled with ACO only - ACO PIDSL if the provider is enrolled with both, ACO and MCO - ACO PIDSL if provider is enrolled with multiple ACOs (e.g., a specialist), and a plan is an active MCO - MCO PIDSL if provider is enrolled with multiple ACOs (e.g., a specialist) and a plan is not an active MCO - old MCO PIDSL • SCO PIDSL for SCO providers One Care PIDSL for One Care providers" *Authorization Type Data Set Elements* table • Field # 1: Org. Code - the length of the field corrected to 4	Alla Kamenetsky
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	Alla Kamenetsky

Date	Revision	Name
	○ 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: "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 Provider ID (PCC Provider ID removed) • Field # 92: PCC Provider ID Type (PCC Provider ID Type removed) • Field # 228: PCC Provider ID Address Location Code	
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" Provider File: • Field #16: Provider Type – corrected datatype to "N"	Alla Kamenetsky
11/09/2017	Few typos corrected	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: ○ Provider ID Address Location Code (Field#36) ○ 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

<table>
<tr><th>Date</th><th>Revision</th><th>Name</th></tr>
<tr><td>09/20/2017</td><td>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</td><td>Alla Kamenetsky</td></tr>
<tr><td>08/14/2017</td><td>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
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
Field#228: PCC Provider ID
Field#229: PCC 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
<table>
<tr><th>Field #</th><th>Field Name</th><th>Former Field Name</th></tr>
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<tr><td>22</td><td>PCC Provider ID</td><td>IPA/PMG ID</td></tr>
<tr><td>31</td><td>PCC Provider ID Type</td><td>IPA/PMG ID_Type</td></tr>
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</td><td>Alla Kamenetsky</td></tr>
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<table>
<tr><th>Date</th><th>Revision</th><th>Name</th></tr>
<tr><td></td><td>
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<tr><td>35</td><td>ACO PIDSL</td><td></td></tr>
<tr><td>36</td><td>Provider ID Address Location Code</td><td></td></tr>
<tr><td>37</td><td>PCC ID Address Location Code</td><td></td></tr>
<tr><td>38</td><td>Provider Network ID TYPE</td><td></td></tr>
<tr><td>39</td><td>Provider Network ID Address Location Code</td><td></td></tr>
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Internal Provider Type Data Set
<table>
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<tr><td>6</td><td>ACO PIDSL</td><td></td></tr>
<tr><td>7</td><td>Provider ID Address Location Code</td><td></td></tr>
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Provider Specialty Data Set Elements
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<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>
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Member Enrollment File
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<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>
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</td><td></td></tr>
<tr><td>06/06/2017</td><td>III. Error Handling
<table>
<tr><td>New error codes added 72*</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>
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* Specific for denied claims only</td><td>Alla Kamenetsky</td></tr>
<tr><td>01/25/2017</td><td>In Service Data segment:

Field # 7 renamed to “Place Holder for Pricing Indicator” (Former “Filler”)
Field # 13 renamed to “Submission Clarification Code”– (Former “Filler”)
Field # 31 “Revenue Code” less than 4-digit codes should be entered with leading zeros.
“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”)

Field #33 “Type of Bill” should be sent in 3-digit format including Frequency as 3rd digit.
Field # 35 renamed to “FILLER” (Former “Type of Service”, which is no longer required).
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>
</table>

Date	Revision	Name
09/09/2016	• I. In Data Elements Clarifications (section 2.0): • Introduced new Inpatient Claim logic for the claims with DOS on or after October 1, 2016. • II. In Table I-B "Service Category (Using the SCO reporting groups)": • Replaced "100" series values with '300' series values. • New Service Categories are in Table I-B1. • Old Service Categories are in Table I-B2.	Alla Kamenetsky
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. • Added information about new BMC SCO to the list of all SCOs throughout the document. • Replaced ICD-9-CM with ICD throughout the document.	Alla Kamenetsky
09/29/2015	• I. In Data Elements Clarifications (section 2.0): • Changed Inpatient Claim logic back to the old definition. • II. In Encounter Data Set Elements (section 3.0): • Changed field #7 description back to "Filler". • "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: • Edited File Processing section • Added a list of the fields that are 100% required to be complete with valid values on all the records. • Removed proposed "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). • 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)	
08/31/2015	I. In Data Elements Clarifications (section 2.0): Added Capitation Payments clarification. Updated Inpatient Claim clarification II. In Encounter Data Set Elements (section 3.0): "Claim Category" (field #2) removed option "7 = Other (should be rarely used)" Changed definition of "Plan Identifier" (field #4) o. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator" Updated definitions of: "Admission Date" (field#15)	Rima Kayyali Alla Kamenetsky

Date	Revision	Name
	"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. In 3.2 Provider Data Set: Added "File Processing" paragraph. 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: Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator". 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: 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) – 30C 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)	

Date	Revision	Name
	‘’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	Updated a name of: Monthly Financial Report in the examples with the current dates on pgs. 62-63.	Alla Kamenetsky
10/30/2014	• Added reference to One Care-ICO • Changed Instructions on Monthly Financial Report. pg62-63 • Changed format of Provider_IDs paragraph on pg.10 • Changed length value in field #86 to 9. pg.47 • Changed length value in field #12 to 10. pg.55. • Changed format of zip file name. pgs. 59-60 • Added Table I-C “Service Category (Using the One Care - ICO reporting groups)” pg.92	Alla Kamenetsky
4/23/2014	• Added clarification in section 2.0 (Diagnosis Codes). • 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	• Changed Encounter Data files submission requirement from fixed-length files to Pipe-delimited text files (delimiter=|) - Section 6.0 • Modified Table I – B (SCO Service Category) – Section 7.0 • Added an appendix for Provider Data File Guidelines – Section 9.0 • Modified “Inpatient Claim” Clarification – Section 2.0 • Added “Administrative Fees” Clarification – Section 2.0 • Added a value of ‘0’ to “Primary Care Eligibility Indicator” field # 33 in Provider Data set – Section 3.1 • Added a clarifying note to “Rate Increase Indicator” Field # 200 – Section 3.0 • Clarified that the monthly financial report should include both MH and Compare 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

Date	Revision	Name
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

CONTENTS

Acronyms

Acronym	Meaning
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan (MCE that submits encounter claims to MassHealth on behalf of Model A ACOs).
DW	Data Warehouse
EOHHS	Executive Office of Health and Human Services
FFSE	Fee-For-Service-Equivalent. The amount that would have been paid by the MCE for a specific service or encounter on a fee for service basis if the service or encounter had not been capitated, paid under a bundled payment, paid partially (such as a withhold), overpaid to be recouped later, or otherwise paid under a risk sharing arrangement.
ICO	One Care Plans
MBHP	Mass Behavioral Health Partnership
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 (MH DW) 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 data for many critical workstreams, including Centers for Medicare and Medicaid Services (CMS, formerly HCFA) reporting, program evaluation, Monthly report production, financial determinations, risk/premium adjustment, performance evaluation in quality measures and utilization, and rate development. It is critical that each Managed Care Entity (MCE), ACO/MCO, MBHP, SCO, and One Care, provides MH DW with encounter claim records accurately reflecting all services provided to Medicaid recipients enrolled in MCEs' managed care program and the total medical cost of care. Only with complete and accurate encounter data can MassHealth fairly assess the effectiveness of MCEs and the managed care program.

All MCEs are required to submit complete, accurate, and timely encounter information on paid claims and related data. Unless otherwise directed by MassHealth, encounter claims are expected to reflect the MCE's actual payment or a Fee-for-Service-Equivalent (FFSE) for the MCE's medical cost of care for the encounter or service as it would be reflected in the MCE's financial reports (excluding IBNR). With the implementation of the ACO project, encounters for both, MCO and ACO, should be submitted in the same file.

For denied claims submissions, please see denied claims submission requirements specifications document.

These specifications provide the requirements for the Paid Encounter file, Provider files, Member file, and Member Enrollment file. All the MCEs, including SCO and One Care, should follow the same format of the files in their submissions.

For the Paid Encounter file submission requirements, please see section 6.0.

For Member and Member Enrollment file submission requirements, please see Appendix C.

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 generally expected to correct the offending claims and send them in a correction file within 5 business days from the date the error reports are posted on SFTP server. The submission-rejection-resubmission cycle must 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 send us an email at "EHS-DL-ENCSPECS@@MassMail.State.MA.US".

1.1 Data Requirements

- The data referred to in this document are encounter data – a record of health care services, health conditions and products delivered for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a visit with a unique set of services/procedures performed for an eligible recipient. Each service should be documented on a separate encounter claim detail line completed with all the data elements including date of service, revenue and/or procedure code and/or NDC number, units, and MCE payments/cost of care for a service or product.

- All encounter claim information must be for the member identified on the claim by Medicaid ID. Claims must not be submitted with another member's identification (e.g., newborn claims must not be submitted under the Mom's ID).

- All claims should reflect the final status of the claim on the date it is pulled from the MCE's Data Warehouse.

- For MassHealth, only the latest version of the claim line submitted to MassHealth is "active". Previously submitted versions of claim lines get offset (no longer "active" with MassHealth) and payments are not netted.

- An encounter is a fully adjudicated service (with all associated claim lines) where the MCE incurred the cost either through direct payment or sub-contracted payment. Generally, at least one line would be adjudicated as "paid". All adjudicated claims must have a complete set of billing codes. There may also be fully adjudicated claims where the MCE did not incur a cost but would otherwise like to inform MassHealth of covered services provided to Enrollees/Members, such as for quality measure reporting (e.g., CPT category 2 codes for A1c lab tests and care/patient management).

- All claim lines should be submitted for each Paid claim, including zero paid claim lines (e.g., bundled services paid at an encounter level and patient copays that exceeded the fee schedule). Denied lines should not be included in the Paid submission. Submit one encounter record/claim line for each service performed (i.e., if a claim consisted of five services or products, each service should have a separate encounter record). Pursuant to contract, an encounter record must be submitted for all covered services provided to all enrollees. Payment amounts must be greater than or equal to zero. There should not be negative payments, including on voided claim lines.

- Records/services of the same encounter claim must be submitted with same claim number. There should not be more than one active claim number for the same encounter. All paid claim lines within an encounter must share the same active claim number. If there is a replacement claim with a new version of the claim number, all former claim lines must be replaced by the new claim number or be voided. The claim number, which creates the encounter, and all replacement encounters must retain the same billing provider ID or be completely voided.

- Plans are expected to use current MassHealth MCE enrollment assignments to attribute Members to the MassHealth assigned MCE. The integrity of the family of claims should be maintained when submitting claims for multiple MCEs (ACOs/MCO). Entity PIDSL, New Member ID, and the claim number should be consistent across all lines of the same claim.

- Data should conform to the Record Layout specified in Section 3.0 of this document. Any deviations from this format will result in claim line or file rejections. Each row in a submitted file should have a unique Claim Number + Suffix combination.

- A feed should consist of new (Original) claims, Amendments, Replacements (a.k.a. Adjustments) and/or 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. See Section 2.0, Data Element Clarifications, for more information.

- While processing a submission, MassHealth scans the files for the errors. Rejected records are sent back to the MCEs in error reports in a format of the input files with two additional columns to indicate an error code and the field with the error.

- Unless otherwise directed or allowed by MassHealth, all routine monthly encounter submissions must be successfully loaded to the MH DW on or before the last day of each month with corrected rejections successfully loaded within 5 business days of the subsequent month for that routine monthly encounter submission to be considered timely and included in downstream MassHealth processes. Routine monthly encounter submissions should contain claims with paid/transaction dates through the end of the previous month.

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 EOHHS MassHealth Data Warehouse 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

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. Other Data Quality checks are noted in the Provider file, Member file, and Member Enrollment file sections.

NOTE: MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCEs, even if the records are currently not rejected for missing or invalid values in some fields. MassHealth reserves the right to introduce additional completeness validation rules.

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.

MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCE.

2.1 Record Type Submission Options and Explanations

Choose the correct Record Type for each claim line depending on the use case. Note the Special Submission requirements.

Record Type	A.K.A.	Use	Special Submission Requirements
O = Original	Original	Initial submission of the claim	No special requirements
A = Amendment	Correction	To correct, update, add missing data elements values of a claim previously loaded in MH DW. Example: an incorrect data mapping to an Encounter field was remediated and impacted claim lines are now resubmitted to the MHDW with an "Amendment" Record Type and the correct value.	Submitted with the Original Claim Number and Suffix Nothing should be entered in Former Claim / Suffix Number fields unless the amendment is for a previously adjusted claim, in which case the amendment record would inherit the former claim number/suffix from the claim it is amending.
V = Void or Back Out	Void	To remove a claim line that was previously loaded in MH DW. Example: A paid claim was later denied. All previously submitted claim lines would be resubmitted with a "Void" Record Type.	Submitted with new Claim Number/Suffix. Claim Number/Suffix of the claim to be voided must be placed in Former Claim Number/Suffix fields
R = Replacement	Adjustment	To replace a claim that was previously loaded in the MH DW with one that has a new claim number. Example: the provider has resubmitted a claim under a new claim number. All previously submitted claim lines must be resubmitted with the new claim number and a "Replacement" Record Type.	Submitted with new Claim Number/Suffix. Claim Number/Suffix of the claim that has to be replaced must be placed in Former Claim Number/Suffix fields. All claim lines need to be replaced with the new claim number. If there are more claim lines in the replacement claim than the original, submit the additional claim as an Original. Visa versa, if there are fewer claim lines in the replacement than the original, void the extra claim lines.

2.2 Claim Number and Suffix

Every Original / Void or Replacement claim submitted to MassHealth should have a new, unique claim number + suffix combination. Duplicate claim number + claim suffix combinations will not be loaded into the MassHealth data warehouse.

2.3 Member IDs

Encounter data records must include MassHealth member IDs that are "active" as of the time of data submission.

2.4 Provider IDs

MassHealth is asking MCEs to provide an identifier that is unique to the MCE. 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

- The Provider ID, Provider ID Type, and Provider ID Location Code should be 100 % present on all provider records.
- 100% of Pharmacy and Physician-Administered Drugs claims must have Billing Provider NPI numbers in provider file
- At least 80% of all the records in the Provider file should have NPI numbers included, or the submission file will be rejected.
- At least 80% of all the records in the Provider file should have Provider Type included, or the submission file will be rejected.
- 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.

2.5 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 in Provider file. MCEs should submit individual (Type 1) or group (Type 2) NPI for billing providers and PCCs.

MH DW will closely monitor submission of servicing/rendering, billing, and referring provider NPI numbers in Provider File. With a change of the business rules, claims with missing NPI numbers in Provider File might be rejected. MCEs will be notified about the change ahead of time.

The above does not apply to "atypical" providers.

2.6 DRG

The DRG field (field #72) is a field requested by CMS. Not all MCEs collect DRGs so MassHealth has developed a preferred course of action:

1. An MCE that collects DRGs- should provide DRG values in data submissions.
2. An MCE 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 MCEs 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.

2.7 Diagnosis Codes

The values in all Diagnosis fields listed in Data Elements section should be submitted when available. Submit on Dental claims when available.

Requirements for validity and completeness are detailed in the ICD clinical guide published by the American Medical Association. Current validating process at MH DW requires:

- at least one diagnosis code (in Primary Diagnosis field #19) for all applicable encounter types as specified in section 8.0.
- diagnosis codes contain the required number of digits outlined in the ICD code books.
- code to the seventh digit when applicable (blank filled when less than seven digits are applicable). DO NOT include decimal points in the code. For example, S72.111A must be entered as S72111A.
- Diagnosis Code must be consistent with ICD Version Qualifier.

Other Guidance:

- On Transportation claims for the services like “a ride to the grocery store”, MCEs should use generic diagnosis codes such as:
  - Z993 – Dependence on wheelchair
  - Z87898 – Personal history of other specified conditions

.

2.8 Procedure Codes

Many MCEs 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 HCPCS Level 1 and II procedure codes is the Procedure Code field (#26). ICD-10 PCS procedure codes should be populated in the Surgical Procedure Code fields (103-111, 206-221).

2.9 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.

2.10 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 MassHealth would expect it to have a Record Indicator value of 4 (Per diem), 5 (DRG) or 6 (Bundled Summary-Level line when none of the other payment arrangements apply).

All detail lines with zero-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 sub-capitation payments, MCEs must report the amounts reported by the provider/vendor on their claims in the Net Payment field (#68) or the Fee-For-Service Equivalent (FFSE) and use Record Indicator value 2 to indicate the FFSE type of payment arrangement. See "Acronyms" section for MassHealth's expectation for an FFSE.

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 Fee-For-Service-Equivalent (FFSE)	Dollar amounts for a service paid under a capitation arrangement or otherwise not reflected in the source system.
3: Encounter Record w/out FFS equivalent	DECOMMISSIONED
4: Per Diem Payment	Use for Per Diem payment arrangements. One line would have the total dollar amount for the day or stay.
5: DRG Payment	Use for DRG payment arrangements. One line would have the total dollar amount for the entire stay.
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.

Record Indicator	Dollar Amount Split
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	Revenue Code	Payment Amount
44444444444	1	4 - Per Diem Payment	0112	0
44444444444	2	4 - Per Diem Payment	0300	0
44444444444	3	4 - Per Diem Payment	0250	0
44444444444	4	4 - Per Diem Payment	0720	0
44444444444	5	0 - Artificial Line: dollar amounts available at summary level only	NULL	10000

Example 2 – Per Diem payment on one claim line with the Room and Board Revenue Code:

Claim Number	Claim Suffix	Record Indicator	Revenue Code	Payment Amount
4444444444A	1	4 - Per Diem Payment	0410	0
4444444444A	2	4 - Per Diem Payment	0300	0
4444444444A	3	4 - Per Diem Payment	0250	0
4444444444A	4	4 - Per Diem Payment	0123	10000

Example 3 - 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 4 – 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

2.11 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

2.12 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.

When there are duplicate services submitted on multiple claim records with different claim number + suffix combinations, MassHealth will consider the record with the latest paid date as the active claim line.

Examples:

Replacements

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Net Payment (#68)	Paid Date
XXX	11111111111	4	1	O			10	7/15/20
XXX	33333333333	4	1	R	11111111111	4	20	8/1/20
XXX	88888888888	4	1	R	33333333333	4	25	9/1/20

Voids

Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Net Payment (#68)	Paid Date	Void Reason Code (#118)
66666666666	1	1	O			15	1/5/2020	
77777777777	2	1	V	66666666666	1	0	3/1/2020	3 (provider audit recovery)

2.13 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.

2.14 MassHealth Inpatient vs. Outpatient Claim Determinations

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".

2.15 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'.

2.16 Physician-Administered Drug Claim Definition

Claims with Claim Category 1 (Facility except LTC) or 2 (Professional) and value in "NDC Number" field (#37).

2.17 Administrative Fees

Administrative Fees such as PBM fees should not be reported in the encounter data as part of the "Net (" (#68). MCEs should inform EOHHS of any arrangement where these fees are included in their claims processing and should work with their PBM or other vendors to separate out the administrative fees from the encounter cost component in their claim processing.

2.18 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 a Replacement or Void 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	Net Payment (#68)
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	Net Payment (#68)
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	Net Payment (#68)
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 – Replacement/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	Net Payment (#68)	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	
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	

Example 5 – Replacement/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	Net Payment (#68)	Record Indicator	Procedure Code
XXX	66666666666	1	O			66666666666	3	0	7	3EA11
XXX	66666666666	2	O			66666666666	3	500	6	G0299
XXX	77777777777	1	R	66666666666	1	77777777777	3	0	7	3EA11

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Net Payment (#68)	Record Indicator	Procedure Code
XXX	77777777777	2	R	66666666666	3	77777777777	3	400	6	G029

2.19 Submission Clarification Code

The Submission Clarification Code (#13, 229, and 230) is populated with a 420-DK-Code when the pharmacist is clarifying the submission. MassHealth requires that a Submission Clarification Code value of 20 be included on the claim when the pharmacy has determined the product being billed is purchased pursuant to right available under Section 340B of the Public Health Act of 1992 including sub-celling purchases authorized by section 340B(a)(10) and those made though the Prime Vendor Program 340B(a)(8).

For additional information about submission clarification code values, please refer to the NCPDP standards. For additional information about submission clarification code values, please refer to the NCPDP standards.

2.20 Provider ID Submission in Encounter and Provider Files

Among several elements introduced in Version 4.6 of these specifications were 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.

Consistent with MassHealth policy for implementing 42 CFR 438.602(b)(1), plans are asked to store the MassHealth Provider Identification number (PIDSL) information that is provided by MassHealth in their systems and provide that information when submitting their ongoing file exchanges as directed by MassHealth, as well as in the event of an audit. When submitting encounter files, MCEs are required to report the MassHealth PIDSL in the “Medicaid Number” field for each provider in their Provider File (field #5).

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

Example: Provider File

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234569	6	04	12345	Smith
999999999R	1234568	6	03	12345	Smith
999999999R	1234567	6	02	12345	Smith

Entity PIDSL	Provider ID	Provider ID Type	Address Location Code	Provider Bundle ID	Provider Last Name
999999999R	1234566	6	01	12345	Smith

2.21 Medicare Related Data

For SCO and OneCare plans, Medicare Code (#11) and Medicare Amount (#63) must be populated accurately and consistently per CMS requirements.

2.22 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 Allowable Amount (#86).

2.23 Recoveries

All claim lines with a payment recovery or other adjustment to the Original claim line related to TPL, accident recovery, or provider audit recoveries must have the Void Reason Code populated (#118), including for all Voids and Replacements. Voids and/or Replacements for provider audit recoveries should include all overpayments recovered or otherwise adjusted as a result of program integrity fraud, waste and abuse controls, including but not limited to provider audits, surveillance and utilization reviews, investigations, post-payment claims edits, algorithms, and provider self-disclosures.

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 sub-sections:

- Demographic Data
- Service Data
- Provider Data
- Financial Data
- Medicaid Program-Specific Data

For the fields that contain codified values (e.g., Patient Status), we use national standard (e.g., UB92 coding standards) values whenever possible.

In the table below "X" indicates a Claim Category the data element is applicable in. The columns are labeled as:

- H – Facility (except Long Term Care)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

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: **MCO / ACPP** 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options **One Care** 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	X	X	X	X	X	3	N
2	Claim Category	Assign claim category based on claim source (e.g., 837i, 837p, 837d). Valid values are:	X	X	X	X	X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		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) Facility encounters with Type of Bill beginning with 2xx (SNF) or 6xx (Intermediate) should be assigned to LTC (Claim Category = 6) with the remainder to Facility/not LTC (Claim Category = 1). *Note:* Section 2.0 Data Element Clarifications explains how MassHealth uses the MCE assigned Claim Category together with Type of Bill to determine Inpatient vs. Outpatient facility.							
3	Entity PIDSL (Provider ID/ Service Location	ACO PIDSL on the ACO claims (an ACO with which a PCC is contracted with) 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 as reported in Net Payment #68. 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 Fee-For-Service-Equivalent (FFSE) - Dollar amounts for a service paid under a capitation arrangement or otherwise not reflected in the source system. 3. DECOMMISSIONED 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 bundled summary-level amounts/quantities as available in the MCE source system. Use this value when none of the above values apply. 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 Dollar Amounts in the ***Data Elements Clarification Section*** for additional instruction.	X	X	X	X	X	1	C
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 ***Claim Number/Suffix*** in the ***Data Elements Clarification*** section.	X	X	X	X	X	20	C
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	Placeholder for Pricing Indicator. MCEs will be notified if implemented.						20	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
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. Medicare code should indicate what part of Medicare is being used to cover the services billed within the claim, NOT all of the parts of Medicare that the member is enrolled in. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B 4 = Part D Only 5 = Part A and D 6 = Part B and D 7 = Part A, B, and D	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. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. 420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment *2.0 Data Element Clarifications* for further information.				X		7	N
14	Claim Type	MBHP Specific field.	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. The date 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. See discussion about Diagnosis Codes in ***Data Element Clarifications*** section, including decimal requirements. *Note:* Primary diagnosis and co-morbidities are for services rendered and thus may not match Admitting Diagnosis. For institutional claims,	X	X	X		X	7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		this would be the Principal Diagnosis Code on Admission from the UB04/837i.							
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See discussion about Diagnosis Codes in ***Data Element Clarifications*** section, including decimal requirements.	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See ***Secondary Diagnosis*** format in the row this one. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	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
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 (#103 – #111, 206-221) ***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, 206-221). 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	X		X			4	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		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: Revenue code -1 - as ‘0001’; Revenue Code 23 - as ‘0023; Revenue code 100 - as ‘0100’; Revenue Code 2100 – as ‘2100’.							
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
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			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: Patient Discharge Status ‘1’ should be submitted as ‘01’; 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 billed 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		X	9	N
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 should not be blank on pharmacy and Physician Administered Drug claims, including for compound drugs.	X	X		X		11	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
38	Metric Quantity	For prescription and physician administered drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. Plans may need to derive the Metric Quantity for physician administered drugs using the procedure code and billed units. Unit of Measure #231 also needs to be populated to indicate the specific type of units counted here (e.g., each tablet, milligrams). *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 product Selection Available 01=Substitution Not Allowed by Prescriber 02=Substitution Allowed-Patient Requested Product Dispensed 03=Substitution Allowed-Pharmacist Selected Product Dispensed 04=Substitution Allowed-Generic Drug Not in Stock 05=Substitution Allowed-Brand Drug Dispensed as a Generic 06=Override 07=Substitution Not Allowed-Brand Drug Mandated by Law 08=Substitution Allowed-Generic Drug Not Available in Marketplace 09=Substitution Allowed by Prescriber but Plan Requests Brand				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 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).					X	6	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
45	Paid Date	For encounter records, the date on which the record was adjudicated (i.e., MCE system generated transaction date).	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	MBHP Specific field	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 Provider ID	. The Provider ID of the Practice the PCP is associated with. Plan's internal provider ID or NPI for the practice.	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, 1 = NPI 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	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	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	1	C
55	Servicing Provider Type	A custom MassHealth code indicating the type of provider rendering the service represented by this encounter or claim. See Table G for values.	X	X	X	X	X	3	N
56	Servicing Provider Specialty	The specialty code of the servicing provider as reported on professional claims. Use CMS 1500/837p standard; see Table H. Optional for facility claims.		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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
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	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 or usual and customary for retail pharmacy if amount provider billed is not available.	X	X	X	X	X	9	N
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. For pharmacy, the amount is what the plan pays the PBM for the drug.	X	X	X	X	X	9	N
62	TPL Amount	Any amount of third-party liability paid by another medical coverage carrier for this service. If this is a recovery, such as an Accident Recovery, the appropriate Void Reason (#118) must also be provided. 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	N
63	Medicare Amount	Any amount paid by Medicare for this service. Must be consistent with Medicare covered services.	X	X	X	X	X	9	N
64	Copay	Any copayment amount the member paid for this service. Patient paid amount for nursing facility stays would be reported in field “Patient Pay Amount”. Medicare copays should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
65	Deductible	Any deductible amount the member paid for this service. Medicare deductibles should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	X	X	X	X	X	9	N
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X		9	N
67	Dispensing Fee	The dispensing fee pharmacy charged for filling the prescription.				X		9	N
68	Net Payment	The amount the Medicaid MCE paid for this service and/or FFSE for the cost that the MCE incurred. MassHealth expects that it would generally equal Allowable Amount (#86) less TPL Amount (#62), Medicare Amount (#63), Copay (#64), Coinsurance (#117), Deductible (#65), Patient Pay Amount (#124) and Withhold Amount (#69). See Section 2.0 for more information about use of Record Indicator to	X	X	X	X	X	9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		indicate the payment arrangement under which the rendering provider was paid. For Pharmacy charges, the amount the Plan paid the PBM.							
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives. See Section 2.0 for more information about Withholds.	X	X	X		X	9	N
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion in Data Elements Clarification section, "Record Type Submission Options and Explanations"***	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: DRG code '1' should be submitted as '001'; DRG code '25' should be submitted as '025'; 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				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:		X				1	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		1 = Maternal Support Services 2 = Infant Support Services							
76	New Member ID	The "active" MassHealth assigned Medicaid identification number for the enrollee that received the services. This number is assigned by MassHealth and is subject to 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	20	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). See report instructions for definitions. Generally, * Assign Service category based on claim source (e.g., 837i, 837p, 837d). * Facility Claims with Type of Bill values 11x and 41x are defined as "Inpatient". Other facility claims would be "Outpatient". * Facility claims with Type of Bill beginning with 2xx (SNF) or 6xx (Intermediate) should be assigned to Institutional Long Term.	X	X	X	X	X	5	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/YYYYMMDD
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No Note that this is not consistent with NCPDP.				X		1	C
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	The maximum amount the plan will pay for the service, which is generally the Plan Allowable Fee Schedule. For retail drugs, it is the	X	X	X	X	X	9	N

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		amount allowed in formulary. Amount reported would equal plan payment + member responsibility.							
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 V, W, X, Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X		8	D/YYYYMMDD
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 Provider ID_Type	One code identifying the type of ID provided in the PCC Provider ID in Field # 49 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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
99	Diagnosis 7	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
100	Diagnosis 8	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
101	Diagnosis 9	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
102	Diagnosis 10	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
104	Surgical Procedure code 2	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
110	Surgical Procedure code 8	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	1	C
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X		X	1	C
114	Other Accident	Is the patient's condition related to Other Accident Y	X	X	X		X	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		N							
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period. For pharmacy claims, may be same amount as Gross Payment Amount (#61) for pharmacy claims if there is no separate charge for uncovered services or copay.	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	9	N
117	Coinsurance	Any coinsurance amount the member paid for this service. Patient paid amount for nursing facility stays would be reported in field “Patient Pay Amount”. Medicare coinsurance should not be reported here as it would be Medicaid MCE responsibility and would be reflected in Net Payment (#68).	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 Must be provided on the record for all adjustments to the Original claim line related to TPL, accident recovery, or provider audit recoveries, including all Voids and Replacements. Recoveries are expected to have a value 1-3. TPL recoveries must also be reflected in TPL Amount field (#62). 4-Other should only be used when 1-3 are not appropriate.	X	X	X	X	X	1	C
119	DRG Description	Description of DRG Code	X		X			132	C
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 (S72.111A as S72111A)
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG. With the exception of DRG 589, valid values are: 1 = minor 2 = moderate	X		X			1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		3 = major 4 = extreme Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields							
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. With the exception of DRG 589, 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.	X		X			9	N
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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
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 (POA) 6	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
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X	X	X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
150	Diagnosis 17	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
159	Present on Admission (POA) 21	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
160	Diagnosis 22	The ICD diagnosis code. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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 about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V, W, X, Y- Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points
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- V,W,X,Y-Code) present on the claim, it should be submitted in this field. See discussion about Diagnosis Codes in Data Element Clarifications section, including decimal requirements.	X		X			7	C/ No decimal points

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
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 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	X	X	X		X	5	C
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	**DEPRECATED AFTER 2014** 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	1	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
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	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	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
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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank.	X					7	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
		See discussion in Data Element Clarifications section, including clarification on ICD-10							
216	Surgical Procedure Code 20	Use for all ICD-10 PCS procedure codes. If not applicable, this value should be left blank. See discussion in Data Element Clarifications section, including clarification on ICD-10	X					7	C
217	Surgical Procedure Code 21	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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	Use for all ICD-10 PCS procedure codes. If not applicable, this 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					15	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	15	C
224	Prescribing Prov. ID Address Location Code	Code to identify address location of Prescribing Provider ID in field # 81				X		15	C
225	PCP Provider ID Address Location Code	Code to identify address location of PCP Provider ID in field # 47	X	X	X		X	15	C
226	Referring Provider ID Address Location Code	Code to identify address location of Referring Provider ID in filed # 52	X	X	X			15	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	15	C

#	Field Name	Definition/Description	H	P	L	R	D	Length	Data Type
228	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID In field # 49	X	X	X	X	X	15	C
229	Submission Clarification Code 2	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment 2.0 Data Element Clarifications for further information.				X		7	N
230	Submission Clarification Code 3	420-DK- Code indicating that the pharmacist is clarifying the submission. For 340b drugs the Submission Clarification Code must be populated with a code value of 20. Please refer to Segment 2.0 Data Element Clarifications for further information.				X		7	N
231	Unit of Measure	To be provided on all Pharmacy and Physician-Administered Drugs claims. The unit of measure for the value entered in "Metric Quantity" field (# 38), e.g., grams, milliliters. Observe industry standard specific to each drug (e.g., HEDIS measure requirements). Please refer to Table O for the allowed values, standard references and available links.	X	X		X		2	C
232	Provider Payment	The Gross Amount that the Plan/PBM paid to the pharmacy for the claim				X		9	N
233	Filler							9	N

** 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).

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.

Example: data string "1234567" would represent $12,345.67

3.1 Provider File Data Set with Record Layout

Data Elements

- This section describes the provider file to be submitted along with each encounter data submission. The file includes a complete snapshot of current provider data at the provider/location level of detail.
- The effective date and termination ("term") date fields provide a history of changes to provider status. The intervals described by these dates should not overlap. All effective date and term date fields should have values. For records describing current status, use '99991231' as the "End of Time" value.
- Provider ID, Provider ID Type and Provider ID Address Location Code values must match the values in corresponding fields in the encounter file.
- Each Provider service location **must** have its own identifier (see definition of the Provider ID Address Location Code below).

#	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: **MCO / ACPP** 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options **One Care** 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	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. Will be used to link back to the Provider ID on the claim.	15	C

#	Field Name	Definition/Description	Length	Data Type
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) Will be used to link back to the Provider ID Type on the claim.	1	C
4	License Number	State license number.	9	C
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider ID). Plans should use information in their systems pursuant to CFR 438.602(b)(1) to populate this field. See Provider ID Submission segment in Section 2.0 for more information.	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
17	Filler		3	C

#	Field Name	Definition/Description	Length	Data Type
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. 0 non-participating provider 1 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. Plan's internal provider ID or NPI for the practice.	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	National Association of Boards of Pharmacy 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 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.	9	C
31	PCC Provider ID Type	A code identifying the type of ID provided in the PCC Provider ID above. 1 = NPI 6 = Internal ID (Plan Specific)	1	C
32	Gender Code	"M" for Male, "F" for Female, and "O" for Other	1	C
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	1	C

#	Field Name	Definition/Description	Length	Data Type
		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".		
34	APCD ORG ID	This is a new field added to get the APCD Provider Organization ID (Org ID) 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	MCO/ACO providers - if the provider is enrolled with MCO only (not with ACO) - MCO PIDSL - if the provider is enrolled with ACO only - ACO PIDSL - if the provider is enrolled with both, ACO and MCO, then ACO PIDSL - if provider is enrolled with multiple ACOs (e.g., a specialist), and a plan is an active MCO - MCO PIDSL - if provider is enrolled with multiple ACOs (e.g., a specialist) and a plan is not an active MCO - old MCO PIDSL SCO PIDSL for SCO providers One Care PIDSL for One Care providers Example: 999999999A	10	C
36	Provider ID Address Location Code	Code to identify address location of Provider ID in Field # 2. Will be used to link back to the Provider ID Address Location Code on the claim.	15	C
37	PCC Provider ID Address Location Code	Code to identify address location of PCC Provider ID in Field # 22.	15	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.	15	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

Requirements for Acceptance of the Providers File

I. All records must contain values in these fields:

1. diOrg. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #3)
4. Provider Last Name (Field #6)
5. Provider First Name (Field #7)
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)
19. Entity PIDSL (Field# 35)

II. NPI must be present on at least 80% of the records.

III. Provider Type must be present on at least 80% of the records.

MCEs must submit valid values for all fields that MassHealth could reasonably expect to be available to MCE. Records are currently not rejected if Medicaid Number/Provider PIDSL (field #5) or Tax ID Number (field #30) are missing values but are nevertheless very important for reporting and decisions. MassHealth reserves the right to introduce additional completeness validation rules.

Example of Provider Bundle ID

This example shows the case when Provider ID is different for every location.

In most cases Provider ID is unique per each provider within the organization and will be the same on every line

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	04	12345	N	Smith	John
888	1234568	6	03	12345	N	Smith	John
888	1234567	6	02	12345	Y	Smith	John
888	1234566	6	01	12345	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. Code that identifies your Organization: **MCO / ACPP** 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England **SCO** 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options **One Care** 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	3	N
2	Provider ID	Provider ID.	15	C

#	Field Name	Definition/Description	Length	Data Type
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	15	C

3.3 Provider Specialty Data Set Elements

Requirements for Acceptance of the Provider Specialties File

All records must include these fields:

1. Org. Code (Field #1)
2. Provider ID (Field #2)
3. Provider ID Type (Field #5)
4. Provider ID Address Location Code (Field #7)

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	DW to each submitting organization. Code that identifies your Organization: MCO / ACPP 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England SCO 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options	3	N

#	Field Name	Definition/Description	Length	Data Type
		506 Boston Medical Center HealthNet Plan Senior Care Options One Care 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)		
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
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: 1 = NPI 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number	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.	15	C

3.4 Additional Reference Data Set Elements (MBHP only)

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	3	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	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	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	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization.	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	Length	Data Type
1	Org. Code	Unique ID assigned in MassHealth DW to each submitting organization	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	Length	Data Type
1	Org. Code	Unique ID assigned by MH DW to each submitting organization	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

#	Field Name	Description	Length	Data Type
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. Amendment processing has been created to allow MCEs to make retroactive changes to the existing claims. "Existing" are the claims that have been accepted and loaded in MH DW.
2. MH DW expects that amendments are used to reflect retroactive dimension changes, such as Member ID, Servicing Category, etc.
3. There are no constraints on timing for submissions of the amendments.
4. Amendments can be sent as a part of a regular submission or as one-off submission. The one-off submission should contain claims file in the format outlined in segment 3.0 "Encounter Data Set Elements" and a metadata file in the format outlined in segment 6.0 "Media Requirements" of this document.
5. Amendments should be submitted with the Type of Feed 'ENC'
6. In submission amendment record is identified by Record Type 'A'. When inserted in MH DW, it inherits the record type of the record it is amending.
7. If the Claim Number + Claim Suffix combination of the 'A' record is not found in MH DW, the record will be rejected with error code 11" Active Original Claim No-Claim Suffix Not Found"
8. If the claim that has to be amended already has Former Claim Number information on a line, that Former Claim Number information should be repeated precisely on the amendment claim
9. All columns should be populated according to the standards like any other submitted claim and should contain post-change values
10. All provider data on the claim must point to a provider reference data.
11. A claim submitted prior to the introduction of Commonwealth Care must have valid data in the Group Number field.
12. Multiple amendments to the same record in the same feed are not allowed and will be rejected with error code "10 - Duplicate Claim No-Claim Suffix -- in same feed".
13. The amendment file loads with the same iterative error process as the regular submission.
14. Dollar amount changes on the claims that happen in the source system, like Replacements and Voids, should be handled via existing process set up to handle those kinds of transactions.

5.0 Error Handling

MassHealth will validate the feeds received from the MCEs and MBHP and return error 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 and Quality Edits, Reasonability and Validity Checks 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	Error Code
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 Code	Error Code
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)

Error Code	Error Code
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.
75	Codes on record are not in sequence

*Applies to the Denied Claims submissions only

All the MCEs including MBHP should resubmit correct records within 5 business days of receiving the error files from MassHealth. This process will be repeated until the number of validation errors is within a 3% threshold. Refer to the "Encounter Data" section of the MassHealth Contract for more details on the action required when data submission is not in compliance with Encounter Data requirements.

6.0 Media Requirements / Encounter Claims Files Submission Requirements

6.1 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.

Note: 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).

6.2 Regular Monthly Encounter File Submission

Filename

The Zip file name should conform to the following naming convention

MCE_Claims_YYYYMMDD.zip

Example:

"BMC_Claims_20210701.zip", where YYYYMMDD -the date of file creation (4 digit year, 2 digit month, 2 digit day) and MCE identifies the Plan according to the following:

MCOs:

- BMC - Boston Medical Center HealthNet Plan
- CHA - Tufts Health Plan
- FLN - Fallon Community Health Plan
- MBH - Massachusetts Behavioral Health Partnership
- NHP - Allways Health Partners
- HNE - Health New England

SCOs:

- CCA - Commonwealth Care Alliance
- UHC – UnitedHealthCare
- NAV - Navicare
- SWH - Molina Healthcare (a.k.a. Senior Whole Health)
- TFT – Tufts Health Plan
- BHP – BMC HealthNet Plan

One Care (ICO):

- CCI - Commonwealth Care Alliance
- NWI – Tufts Health Unify
- UCC – UnitedHealthCare Connected

6.3 Project Related Filename

Names of the files submitted for the special projects should have an extension up to 6 characters after the date part of the name. For example, the files submitted for the J-Code project might have an extension “JCODE” in the name of the file.

Example:

“MCE_Claims_YYYYMMDD_JCODE.zip”

MH DW will give the MCEs specific instructions on the file naming standards related to specific projects.

6.4 The Manual Override File

A manual override file will override many of the claim line rejection edits intended to ensure quality data. Use with caution. Use only in limited circumstances when Plan is confident that the plan data is correct and the edit is wrong, e.g., a new NDC code is used which is not yet included in MassHealth’s reference table.

The manual override file should be named MCE_Claims_YYYYMMDD_MO. The “_MO” files should be sent only after the MCEs have corrected and re-submitted records rejected when the regular submission fie was processed. Corrections should be sent with “ENC” file.

Note: See description of “ENC” in Metadata file fie paragraph below.

The manual override file should have a file type of EMO in the metadata file.

6.5 Zip 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

6.6 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) Names of the files in the metadata file must match the names of the actual files in submission
b) Send a zero byte None.txt for missing files - provider or specialty and set corresponding field value to "None.txt"
c) A file posted on SFTP server must have a unique name
d) Discrepancy between the actual feed and the values in Metadata file fields Total Net Payments and/or Total Records results in rejection of the entire feed.
e) The names of the fields in Metadata file should match the spelling suggested in the spec (Example: Total Net Payments)
f) From a processing perspective there is no difference between the original submission file, a correction file, and an Amendment file. All these types of submissions should have Type_ Of_ Feed = ”ENC” in metadata file

6.7 Secure FTP Server

MassHealth has set up a Secure FTP server for exchanging data with the MCEs. SFTP folder access is restricted to plan users that are approved by MassHealth. User can email EHS-DL-IT Requests for instructions.

Details of the server are below:

- *Server:* virtualgatewaydw.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 ad hoc data to MassHealth.

6.8 Sending Encounter data

Transfer encounter data file in a 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.

- Refrain from sending several files with the same name.
- Only one submission of a kind (claims or member) can be placed on the server at any point of time. You may post the next file when the notification of the previous file load is received.
- If a second file is a project specific, please work with MH DW to follow the instructions on file submission related to the project

6.9 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. Note that error files are replaced with every new file load. 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. You will not receive a notice if a file could not be processed (errored out).

6.10 CMS Internet Security Policy [Removed]

7.0 Standard Data Values

This section contains tables that identify the standard coding structures for several of the encounter data fields.

NOTE: Tables F, J and L do not exist in these specifications.

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 O UB-4 UNIT OF MEASURE

Note: The abbreviation "**NEC**" after a description stands for ***Not Elsewhere Classified***.

TABLE A – Type of Admission (UB)

Table A below represents the 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
A	RESERVED FOR ASSIGNMENT BY THE NUBC (END 10/1/07)
B	TRANSFER FROM ANOTHER HOME HEALTH AGENCY

For Newborns

The following table represents the values for newborns:

Value	Description
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

TABLE C – Place of Service (HCFA 1500)

Place of Service Codes for Professional Claims

CMS Database (as of 12/2021)

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	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017) The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022)
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	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. This code is effective January 1, 2022, and available to Medicare April 1, 2022.

Value	Place of Service Name	Place of Service Description
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)
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, campground, 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	Place of Employment-Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
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	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
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.

Value	Place of Service Name	Place of Service Description
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 newborn 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 individuals with intellectual disabilities.
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.
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.

Value	Place of Service Name	Place of Service Description
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/ Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to 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	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). (Effective January 1, 2020)
59	Unassigned	N/A
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)

Value	Place of Service Name	Place of Service Description
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.

TABLE D – Type of Bill (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

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 or other Servicing Provider Type not listed
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

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

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

Value	Description
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
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
41	Optometrist

Value	Description
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
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology

Value	Description
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 the claims with Dates of Service before 07/01/2010**.

TABLE I – B1: Service Category (Using the SCO reporting groups)

Note: For the Claims with Date of Service on or after October 1, 2016

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
309B	Pharmacy/Drugs (non-Part D)
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: For the Claims with Date of Service before October 1, 2016

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

Value	Description
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	Long-Term Care (LTC) Facility
213	Home 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)

CMS POA Indicator Options and Definitions

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission.
U	Documentation was insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider was unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

CMS updated as of 12/21

TABLE O – UNIT OF MEASURE

#	Unit	Description	POPS Suggested Rules
1	F2	International Unit (for example, anti-hemophilia factor)	Physician Administered Drug claims only
2	GR	Gram (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
3	ME	Milligrams (for creams, ointments, and bulk powder)	Physician Administered Drug claims only
4	UN	Unit (for tablets, capsules, suppositories, and powder filled vials)	Physician Administered Drug claims
5	ML	Milliliters (for liquids, suspensions, and lotions)	Physician Administered Drug claims **and** Pharmacy
6	EA	Each	Pharmacy claims only
7	GM	Gram	Pharmacy claims only

Unit of Measure Reference

Retail Pharmacy Type

- Source: NCPDP
- Unit of Measure (NCPDP 600-28)
- Valid values: EA, GM, ML

Medical Type:

- Source: CMS Guidance (https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53111)
- Valid values: UN, GR, ML, F2, ME

#	Unit	Standard Referenced	Available Link
1	F2	ANSI 5010 837P and ANSI 5010 837I	
2	GR	ANSI 5010 837P and ANSI 5010 837I	
3	ME	ANSI 5010 837P and ANSI 5010 837I	
4	UN	ANSI 5010 837P and ANSI 5010 837I	https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/entry/53111
5	ML	ANSI 5010 837P, ANSI 5010 837I, and NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
6	EA	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf
7	GM	NCPDP	NCPDP: http://www.ncpdp.org/NCPDP/media/pdf/BUS_fact_sheet.pdf

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- File layout format
- Length and data type of the fields
- 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 quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports

Claims File

#	Field Name	MassHealth Standard
1	Org. Code	100% present and valid per field requirement.
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Entity PIDSL	100% present on all encounters
4	Record Indicator	100% present and valid per field requirement.
5	Claim Number	100% present and valid per field requirement.
6	Claim Suffix	100% present and valid per field requirement.
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 and valid per field requirement.
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 on Pharmacy and Provider-Administered Drug claims
14	Claim Type	100% present and valid for MBHP only
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 Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
17	From Service Date	100% present and valid date on all claims.
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. See Diagnosis segment in Data Element Clarifications for additional requirements.
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.

#	Field Name	MassHealth Standard
		Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
21	Tertiary Diagnosis	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
22	Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
23	Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
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 professional claims.
33	Type Of Bill	100% present and valid on all Inpatient and Long-Term Care claims
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, LTC claims, 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.

#	Field Name	MassHealth Standard
49	PCC Provider ID	Must match PCC Provider ID 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.
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 for Professional Claims (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	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
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

#	Field Name	MassHealth Standard
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.
92	PCC 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. Codes must be in sequence with no empty fields in between.
99	Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
100	Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
101	Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
102	Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
103	Surgical Procedure code 1	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
104	Surgical Procedure code 2	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
105	Surgical Procedure code 3	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
106	Surgical Procedure code 4	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
107	Surgical Procedure code 5	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
108	Surgical Procedure code 6	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
109	Surgical Procedure code 7	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
110	Surgical Procedure code 8	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
111	Surgical Procedure code 9	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
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	100% present on all claims with Record Type “V”
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
132	Present on Admission (POA) 5	Provide if Diagnosis 5 is available on Hospital and Long-Term Care claims

#	Field Name	MassHealth Standard
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
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. Codes must be in sequence with no empty fields in between.
159	Present on Admission (POA) 21	Provide if Diagnosis 21 is available on Hospital and LTC claims
160	Diagnosis 22	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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. Codes must be in sequence with no empty fields in between.
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

#	Field Name	MassHealth Standard
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
200	Rate Increase Indicator	Provide if applicable
201	Bundle Indicator	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
202	Bundle Claim Number	100% present if Bundle Indicator=” Y”.
203	Bundle Claim Suffix	100% present if Bundle Indicator=” Y.
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. Codes must be in sequence with no empty fields in between.
207	Surgical Procedure Code 11	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
208	Surgical Procedure Code 12	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.

#	Field Name	MassHealth Standard
209	Surgical Procedure Code 13	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
210	Surgical Procedure Code 14	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
211	Surgical Procedure Code 15	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
212	Surgical Procedure Code 16	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
213	Surgical Procedure Code 17	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
214	Surgical Procedure Code 18	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
215	Surgical Procedure Code 19	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
216	Surgical Procedure Code 20	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
217	Surgical Procedure Code 21	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
218	Surgical Procedure Code 22	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
219	Surgical Procedure Code 23	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
220	Surgical Procedure Code 24	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
221	Surgical Procedure Code 25	Provide if available. Consistent with ICD Version Qualifier. Codes must be in sequence with no empty fields in between.
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 Provider ID is present
229	Submission Clarification Code 2	Provide on Pharmacy and Provider-Administered Drug claims
230	Submission Clarification Code 3	Provide on Pharmacy and Provider-Administered Drug claims
231	Unit of Measure	100 % present and valid on Pharmacy and/or Physician-Administered Drug claims
232	Provider Payment	Provide when available
233	Filler	

9.0 Appendices

Appendix C – Member File and Member Enrollment File Specifications

Overview

MCEs are required to submit member enrollment data on a monthly basis along with Encounter data submission. Member level enrollment data are needed for multiple EHS projects.

For example, the updated Member Enrollment File captures member enrollment with a PCP and member demographics.

Member File Layout

#	Field	Description	Length	Type	Required	Comments
1	Org. Code	Unique ID assigned by MH DW to each submitting organization. Code that identifies your Organization: MCO / ACPP 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England SCO 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options One Care 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	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 YYYY MMDD	Required	

#	Field	Description	Length	Type	Required	Comments
5	Member Death Date	Member Date of Death	8	Date YYYY MMD D	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	
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: MCO / ACPP 465 Fallon Community Health Plan 469 Allways Health Partners (a.k.a. Neighborhood Health Plan) 997 Boston Medical Center HealthNet Plan 998 Tufts Health Plan (a.k.a. Network Health) 999 Massachusetts Behavioral Health Partnership 470 CeltiCare - Retired 471 Health New England SCO 501 Commonwealth Care Alliance 502 United HealthCare (a.k.a. Evercare) 503 NaviCare 504 Molina Healthcare (a.k.a. Senior Whole Health) 505 Tufts Health Plan Senior Care Options 506 Boston Medical Center HealthNet Plan Senior Care Options One Care 601 Commonwealth Care Alliance 602 Tufts Health Unify (a.k.a., Network Health) 603 Fallon Total – Retired 604 United HealthCare Connected (new)	3	N	Required	
2	Member ID	The MassHealth ID for the member	12	C	Required	
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.

#	Field	Description	Length	Type	Required	Comments
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	
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.
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.	1	C	Required	This ID Type should be consistent with the ID Type submitted in the

#	Field	Description	Length	Type	Required	Comments
		The values are: 1 for NPI 6 for MCE Internal ID				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	Provider ID Address Location Code	Code to identify address location of Provider ID in Field #8	15	C		
13	Practice ID Address Location Code	Code to identify address location of Practice ID in Field #10.	15	C		
14	Entity PIDSL	ACO PIDSL for the ACO claims and MCO PIDSL for the MCO claims SCO PIDSL on SCO claims One Care PIDSL on One Care claims Example: 999999999A	10	C	Required on all records	Should be consistent with ACO PIDSL submitted in the encounter provider file

Technical Specifications

MCEs should submit a full refresh of the Member and the Member Enrollment 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 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 and changes in Practice affiliation.
4. Members who are enrolled with an MCE and are in the Member File, but do not have PCP 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.

Member Enrollment File Providers and Practices

1. PCPs are considered "Providers", and their IDs should be submitted in the Provider ID field.
2. 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.
3. 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.
4. A "Provider Enroll Type" field indicates that the Provider ID is for a PCP.
5. A "Care Level" field indicates whether the CM Provider IDs are submitted at the MCE or Practice/Provider level.
6. 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.
7. Every Provider ID for a PCP and every Practice ID must exist in the Provider File submitted in the Encounter file.

8. 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

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.
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)

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, and Member Metadata File.
3. Member File and Member Enrollment 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. It should be placed on SFTP server after the claims zip file is posted.
6. A zero-byte file "mem_mce_done.txt" must be placed on SFTP server along with 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_20210930.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.

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:
    a) Member ID is missing
    b) Member ID is invalid
    c) Org. Code is missing
    d) Org. Code is not meeting MassHealth Standards
    e) Entity Identifier is not meeting MassHealth Standards
3. Member File data are not used in the claims validation process. Rejected Member File records do not affect encounter claims data load.
4. It is expected that values be collected and submitted for all fields. For example, Member Ethnicity (field #10), Member Race (field #11), and Member Primary Language (field #12) are fields that are not currently validated but that are nevertheless expected and important for determining new policies that improve care to Members.

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) The records get rejected if:
    a) Member ID is missing or invalid
    ~~b)~~ Provider ID is missing or invalid (not found in MCE Provider Files)
    c) Provider ID Type is missing or invalid (not found in MCE Provider Files)
    d) Provider ID address location code is missing or invalid (not found in MCE Provider Files)
    e) Practice ID Type or Practice ID Address Location Code is missing when Practice ID is provided
    f) Practice ID Type not found in MCE Provider File
    g) Provider Enroll Type is missing
    h) Provider Enroll Type is not valid as per specification
    i) Care Level is missing or is not valid as per specification
    j) Begin Enrollment Date is missing or invalid
    k) End Enrollment Date is missing or invalid
    l) Org. Code is missing or invalid

4) Member Enrollment File data are not used in claims validation process.
5) Rejected Member Enrollment File records do not affect encounter claims data load.
6) Records are currently not rejected if the values in other fields are missing or invalid (e.g., Entity PIDSL is missing or doesn't match MMIS). However, these fields are nevertheless very important for reporting and decisions. MassHealth reserves the right to introduce additional completeness validation rules.

Member and Member Enrollment Error Files:

1. All records in the Member File, Member Enrollment 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. Records that get rejected must be corrected and sent back to MassHealth to get into the system.
5. Member and Member Enrollment correction files should follow the same format as the original files
6. 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.
7. Corrected records in Member File, Member Enrollment 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.

Appendix F – MassHealth ACPP Service Areas

Contractor's Service Area (as indicated by "X")	Service Area
X	ADAMS
	ATHOL
X	ATTLEBORO
X	BARNSTABLE
X	BEVERLY
X	BOSTON - PRIMARY
X	BROCKTON
X	FALL RIVER
X	FALMOUTH
X	FRAMINGHAM
X	GARDNER-FITCHBURG
	GLOUCESTER
	GREENFIELD
X	HAVERHILL
X	HOLYOKE
X	LAWRENCE
X	LOWELL
X	LYNN
X	MALDEN
X	NANTUCKET
X	NEW BEDFORD
X	NORTHAMPTON
X	OAK BLUFFS
X	ORLEANS
	PITTSFIELD
X	PLYMOUTH
X	QUINCY
X	REVERE
X	SALEM
X	SOMERVILLE
X	SOUTHBRIDGE
X	SPRINGFIELD
X	TAUNTON
X	WALTHAM
X	WAREHAM
X	WESTFIELD
X	WOBURN
X	WORCESTER

Appendix G:
Behavioral Health

Exhibit 1: Community Behavioral Health Center (CBHC) List

CBHC	CATCHMENT AREA
North Suffolk Mental Health Association	Greater Boston
Cambridge Health Alliance	Boston/Cambridge
Boston Medical Center	Boston/Brookline
Riverside Community Care	Norwood
Aspire Health Alliance	South Shore
The Brien Center	Berkshires
Clinical Support Options	Greenfield
Clinical Support Options	Northampton
Behavioral Health Network (BHN)	Southern Pioneer
Center for Human Development	Southern Pioneer
Advocates	Metrowest
Clinical Support Options	North County
Community Healthlink	North County
Riverside Community Care	South County
Community Healthlink	Worcester
Eliot Community Health Services	North Essex
Beth Israel Lahey Behavioral Services	Lawrence
Vinfen	Lowell
Eliot Community Health Services	Tri-city
Child and Family Services	Southern Coast
High Point Treatment Center	Brockton

CBHC	CATCHMENT AREA
Bay Cove Human Services	Cape Cod
Fairwinds- Nantucket's Counseling Center	Nantucket
Child and Family Services	Fall River
Community Counseling of Bristol County	Taunton Attleboro

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Exhibit 2: **State-Operated Community Mental Health Centers** (SOCMHCs)

Brockton Multi-Service Center 165 Quincy Street Brockton, MA 02402
John C. Corrigan Mental Health Center 49 Hillside Street Fall River, MA 02729
Mass. Mental Health Center 75 Fenwood Road Boston, MA 02115
Pocasset Mental Health Center 830 Country Road Pocasset, MA 02559

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Exhibit 3: State Operated Facilities Providing Inpatient Mental Health Services, Outpatient Behavioral Health Services, and Diversionary Behavioral Health Services

Type of Service/Appendix C Category	Provider Name	Location	NPI	Claim Form[1]	Service
Hospital Based Services	Cape Cod and Islands Mental Health Center	Pocasset	1851477491	UB04	Inpatient Services
Hospital Based Services	Corrigan Mental Health Center	Fall River	1700964947	UB04	Inpatient Services
Hospital Based Services	Corrigan Mental Health Center	Fall River	1194803288	UB04	Outpatient Services*
Hospital Based Services	Cape Cod and Islands Mental Health Center	Pocasset	1851477491	1500	Professional Services
Hospital Based Services	Corrigan Mental Health Center	Fall River	1700964947	1500	Professional Services
Diversionary Services	Substance Abuse Program "WRAP"	Taunton	1508212416	1500	Acute Treatment Services
Diversionary Services	Substance Abuse Program "WRAP"	Taunton	1508212416	1500	Clinical Support Services
Clinic services	Brockton Multi-Service Center	Brockton	1326155458	1500	Clinic
Clinic services	Mass Mental Health Center	Boston	1073638805	1500	Clinic

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[1] Professional services are also billed for these programs on a 1500 claim form.

Exhibit 4: Public and Private Institutions for Mental Disease (IMD)[2]

Private IMDs – Inpatient Hospital Services

(As of May 2019)

Provider ID	Hospital Name	NUM_TAX_ID	Provider Type
110026750A	AdCare Hospital of Worcester	042053042	74
110020804E	Arbour Hospital	232238962	73
110027416A	Arbour HRI Hospital Inc	232238958	73
110027414A	Bournewood Hospital	042844287	73
	Brattleboro Retreat Hospital (VT)		73
110027429A	Fuller Hospital	232801395	73
110032615B	Hampstead Hospital (NH)		73
110150907B	Haverhill Pavilion		73
110150798B	Hospital for Behavioral Medicine		73
110027417A	McLean Hospital (Partners HealthCare)	042697981	73
110027393D	Pembroke Hospital		73
110105912B	Southcoast Behavioral Health		73
110027437A	Walden Behavioral Care	200060125	73
110119411A	TaraVista Behavioral Health Care		*73*
110131276B	Westborough Behavioral Healthcare Hospital		73

Public IMDs - State-Owned Non-Acute Hospitals Operated by the Department of Mental Health
(As of June 2014)

Provider ID	DMH Hospital Name
110000091G	SC Fuller Mental Health Center
110000084H	Taunton State Hospital
110000091D	Worcester State Hospital

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[2] In accordance with 42 CFR 438.3(e)(2) and 438.6(e)

Exhibit 5

DEPARTMENT OF MENTAL HEALTH
DIVISION OF CLINICAL AND PROFESSIONAL SERVICES
LICENSING DIVISION – BULLETIN #19-01
March 1, 2019

Clinical Competencies/Operational Standards for DMH Licensed Inpatient Facilities

This bulletin, and the attachments hereto are issued pursuant to Department of Mental Health (DMH) regulations 104 CMR 27.03(5)&(8), which provide that DMH "may establish clinical competencies and additional operational standards for care and treatment of patients admitted to facilities[3] licensed pursuant to 104 CMR 27.00, including for specialty populations." The purpose of this regulatory provision is to assist the Department in assuring that DMH licensed facilities have the capability to provide the level of care needed by individuals who meet criteria for inpatient hospitalization, thereby increasing access to services required by citizens of the Commonwealth.

The attached clinical competencies/standards were developed by a broad stakeholder group that included DMH clinical and licensing staff, representatives of DMH licensed facilities, public and commercial payers, and professional trade associations. They are intended as guidelines to inform practice and to provide a baseline for DMH licensing reviews of individual facility's compliance with licensing regulations. The competencies/standards cover the following areas:

- Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric units within General Hospitals
- OMITTED
- Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk
- Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ID/DD)
- Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

While it is expected that all facilities will generally be able to meet the clinical competencies/standards (including provision of services and equipment), it is not necessarily expected that each facility will have the resources or staff available at all times to meet all competencies and standards at all times, as circumstances within facility at any given time may limit its ability to be in compliance. Facilities must, however, have a plan in place to provide additional staff coverage or equipment as may be needed to facilitate admission of patients who require such coverage or equipment, and should be prepared to engage with public and commercial payers proactively as indicated.

The DMH Licensing Division will begin referring to the attached competencies/standards in its licensing reviews beginning May 1, 2019.

Questions regarding this bulletin should be directed to the DMH Licensing Division at 617-626-8117 or

[3] The term "facility" as used in this bulletin includes DMH licensed units within general hospitals.

DMH.Licensing@massmail.state.ma.us.

Attachments:

Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric units within General Hospitals

OMITTED

Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)

Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

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Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Co-Occurring Medical Conditions

Psychiatric Units within General Hospitals

Psychiatric units in general hospitals are expected to have the capability, or the ability to secure the capability within a reasonable period of time (in hours or, for very complex medical care needs, days), to provide necessary medical care to patients requiring inpatient psychiatric hospitalization who also have medical conditions requiring the following services.

Each inpatient psychiatric unit in a general hospital shall have policies to assure that it has the capacity to provide care for persons with the following medical needs or conditions. If resources are not immediately available for patients with certain medical conditions, the facility must have a plan to secure the resources necessary to provide the care (e.g., securing "just in time" training for nurses from a specialty nurse educator, availability of a specialist to consult with the attending psychiatrist, etc.) through training, supplemental staff, etc. within a reasonable period of time:

- Intravenous (IV) hydration
- Continuous Positive Airway Pressure (CPAP)
- Diabetes Care
- Oxygen Therapy
- Alcohol Detoxification (See specific competencies required for treatment of co-occurring Substance Use Disorders)
- Opiate Detoxification (See specific competencies required for treatment of co-occurring Substance Use Disorders)
- Methicillin-resistant Staphylococcus aureus (MRSA) or other antibiotic-resistant infections or communicable infections
- Assistive devices/specialty equipment (e.g., walkers, canes, wheelchairs, hospital beds, specialty mattresses)
- Occupational Therapy (OT)/ Physical Therapy (PT)
- Anticoagulation therapies
- Eating disorders
- Incontinence
- Foley catheter
- Ostomy care
- Seizures – History and/ or risk of
- Respiratory conditions
- Wound care (any stage)
- Patient in need of in-house Lab services
- Patient in need of internal medicine resources on site

Each facility shall ensure that all staff designated to provide the listed services receive education and demonstrate competencies (i.e., upon hire, as needed, and/ or annually) that are consistent with their role in

patient care regarding the above competencies. Each facility shall further ensure that medical and nursing care staff are trained in and can demonstrate knowledge of the facility's policy or plan for securing the resources necessary to provide the listed services and to provide just-in-time training to all staff who will provide care to the patient being admitted.

DMH recognizes that some capabilities may be beyond the capacity of certain general inpatient units within general hospitals. It is necessary; however, that these capabilities be present within the Commonwealth's hospital system, even if they may require extra resources, transportation or preparation. Facilities are encouraged to develop these capabilities, either through direct service arrangements, affiliations with outside providers or otherwise. These capabilities include, but are not limited to:

- IV medications
- Bilevel Positive Airway Pressure (BiPAP)
- Dialysis
- Suction
- Nasogastric (NG) Tube
- Eating disorders – severe restrictive or purging
- Pregnancy

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - ***Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization and who present with high level of acuity, including severe behavior and assault risk.

Each general inpatient psychiatric facility shall assure that it has the capacity to:

- Provide treatment to patients with severe behavior/assault risk, including evaluating patients during the intake and admissions process to determine if additional staffing supplementation is required.
- Adjust staffing levels to meet varying levels of unit acuity.
- Evaluate and document care needs during the referral and acceptance process which serves as preparation for direct care staff and others to incorporate risk and individualized crisis prevention planning (ICPP) upon admission. (While safety tools are generally completed within 48 hours of admission, a person admitted with this risk level should have their safety tool or ICPP completed as soon as possible after arrival.)
- Provide a range of intervention approaches to address the needs of patients with higher levels of acuity. Aggressive, assaultive patients may benefit from behavior management plans, anger management, relaxation techniques, occupational therapy, and social skills development. Consideration for consultation with behavior specialists should be given.
- Provide ongoing training and demonstration of competencies in verbal de-escalation, including hands on experience, to reduce likelihood of harm.

  De-escalation and Preventative Skills that can assist direct care staff to safely respond to patient agitation or aggression include but are not limited to:

  - Motivational Interviewing
  - Trauma Informed Care
  - Person-Centered Approaches
  - Stigma/ Countertransference
  - Mindfulness
  - Flexible Rules
  - Strength-based interventions
  - Approachability of staff for providing help
  - Anger Management
  - Leadership Rounds regularly on units
- Security specialists/ guards who may participate in direct interactions with patients experiencing episodes of severe behavior or assault risk should have training (e.g., CPI, Handle With Care, MOAB) that is consistent with training received by the direct care psychiatric inpatient staff, as should any additional staff who may participate in such episodes.
- Ensure robust debriefing processes, including incidents that qualify as “near misses.”
- Provide Medication Management with proactive use of PRNs and use of withdrawal protocols as indicated.

- Ensure that staff on all shifts have access to Sensory Tools, and the training required to select and work with patients to use these tools as coping skills and methods for decreasing frustration and aggression.
- Involve community treaters, state agency representatives, and the legal system (if involved) in treatment and discharge planning as soon as possible after admission in order to assess the patient's current continuum of care and foster successful outcomes.
- Ensure that wraparound community services are in place (e.g., get/fill medications, an outpatient medication/injection clinic (if needed), access transportation to appointments, stable housing, and case management).
- Engage patients who are identified as having "personality disorders or traits," utilizing Trauma Informed Care (TIC), Motivational Interviewing (MI), Sensory Tools, attention to diet (e.g., polydipsia, excessive caffeine or sugar intake), and Mindfulness Training.
- Work with court system, families and/ or guardians to expedite the process of commitment if necessary.
- Provide increased security presence, specialized psychopharmacology interventions, and active treatment with the patient to identify and practice greater behavioral control skills.
- Ensure all staff receive consistent education and maintain current trainings and certifications (i.e., upon hire, as needed, and annually) to work with and care for these patients.

Each general inpatient psychiatric facility is recommended to consider:

- When possible, create flexibility in the physical plant for non-restraint and seclusion management of behavior. This can involve providing special observation/single rooms and higher staffing ratios for patients requiring assault precautions to mitigate the risk to roommates and other patients on the unit. It is ideal that a unit be able to provide a distinct, spacious area for the most acute patients with specialized group programming, activity space, and comfort space (if possible). Patients could move to the regular section of the milieu when able to tolerate more stimulation.
- Consideration should be given to the inclusion of Peer Support Specialists in milieu treatment.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See ***DMH Licensing Bulletin #18-01 - Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ID/DD)

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization, who present with Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ID/DD), but who do not require specialized treatment due to their ASD/ID/DD beyond the competencies listed below.

Each general inpatient psychiatric facility shall assure that it has the capacity to:

- Provide care to patients with mild to moderate presentations of Autism Spectrum Disorder or other intellectual and/or developmental disabilities whose baseline level of functional impairment is mild to moderate as well. Patients with significant maladaptive behavior, inability to maintain ADLs, as well as those with significant self-injurious or violent behavior, due to their ASD/ID/DD may have needs that exceed the expected capability of a general inpatient psychiatric unit.
- Recognize the clinical needs of common co-occurring physical conditions that are associated with many patients with ASD/ID/DD (e.g., severe constipation, diarrhea, urinary tract infections, food allergies, etc.).
- Provide sensory supports for varying levels of functioning.
- Ensure all staff receive consistent education and maintain current trainings (i.e., upon hire, as needed, and annually) to work with and care for this population.
- Provide ongoing trainings and demonstration of competencies in de-escalating behaviors of patients with ASD/ID/DD, as part of the general de-escalation program.
- Evaluate and document care needs during the referral and acceptance process, and use this information to incorporate the inclusion of behavioral triggers/warning signs, as well as strengths, motivators and any sensory tools that have been successfully employed for direct care staff and the multidisciplinary team.
- Notify and collaborate with the Department of Developmental Services, as appropriate and with the Department of Education (DOE), town or city special education departments to ensure the continuity of special education services for eligible students.
- Engage the Children's Behavioral Health Initiative (CBHI) teams, Department of Education (DOE) teams, DMH, and/or DDS for consultation and discharge planning as needed.
- Minimize the difficulty with transitions, especially by providing discharge information to care managers and outpatient services. Ideally, the same team members (both inpatient and outpatient) would work with these patients as they move across the care continuum.
- Work with families and other caregivers before discharge to enhance successful transition of level of care and reduce recidivism.

Each general inpatient psychiatric facility is recommended to consider:

- Flexible availability of a separate, designated, less stimulating space is best.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include

the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 ***- Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Co-Occurring Substance Use Disorders (SUD)

The Department of Public Health Bureau of Substance Addiction Services (BSAS) licenses inpatient psychiatric facilities that also provide a separate, identifiable inpatient SUD treatment program. Such units/ facilities are required to be dually licensed by DMH and BSAS.

A DMH licensed facility that provides SUD treatment or services, such as medication assisted treatment (MAT), incidental to the evaluation, diagnostic and treatment services for which it is licensed under 104 CMR 27.00, and that does not offer a separate, identifiable inpatient substance use disorder treatment unit or program, or represent themselves to the public as providing substance use disorder treatment or services as a primary or specialty service, must comply with DMH licensing requirements at 104 CMR 27.03(11) but is not subject to BSAS licensure requirements.

As part of its licensure obligations under 104 CMR 27.00, each inpatient psychiatric facility that is not subject to BSAS licensure shall assure that it has the capacity to:

- Identify potential for addictive disorders through evidence-based screening and assessment tools during the admission assessment process.
- Evaluate for, order, assess, and provide medication assisted treatments for alcohol, benzodiazepine, and opioid withdrawal and for addictions to these substances within limitations of licensure. Medication assisted treatment, education, orientation, and initiation is required when clinically indicated. (See SAMHSA Treatment Improvement Protocol 63 –Medications for Opioid Use Disorder)
  - This includes:
    - Assessing the patient for the appropriateness of induction on MAT using one of the three FDA-approved medications for the treatment of Opioid use disorder: buprenorphine, methadone, or naltrexone; and
    - Ensuring that once an induction begins, referrals for an outpatient provider (ex. OTP, OBOT) are secured.
  - Any physician or other authorized hospital staff in DMH-licensed inpatient facilities can administer or dispense methadone and buprenorphine without additional state or federal oversight or approval, provide the methadone or buprenorphine is administered or dispensed incident to the patient's medical treatment for a condition other than substance use disorder. This includes MAT induction for a patient with a secondary diagnosis of substance use disorder on either methadone or buprenorphine.
    - DEA regulations[4] authorize physicians or other authorized hospital staff to administer or dispense buprenorphine or methadone in the hospital, which includes psychiatric hospitals, in order to maintain or detox a patient "as an incidental adjunct to medical or surgical treatment of conditions other than addiction". In effect, this allows a physician

[4]21 CFR Part 1306.07. Note that these regulations also include the "three-day rule", which allows any physician to administer methadone or buprenorphine without additional state or federal oversight or approval. This includes MAT induction for a patient being treated for acute withdrawal symptoms. The rule allows MAT treatment to relieve acute withdrawal symptoms, provided the treatment is limited to 72 hours where not more than one day's medication is administered to a person at a time. The 72-hour period cannot be renewed. For more information, see 21 CFR Part 1306.07(b).

or other authorized hospital provider to administer or dispense MAT to patients at the hospital, without time limitation, where SUD is a secondary diagnosis.
  - Practitioners who are DATA- waived[5] can prescribe, administer, or dispense buprenorphine to patients in DMH-licensed inpatient facilities.
- Administer opioid antagonist, if needed. All units must have naloxone available on unit and staff trained to order/administer.
- Provide group and/ or individual therapeutic programming and patient education, provided by appropriately trained staff, which addresses recovery and relapse prevention planning related to SUD. Engage, inform, and support parents and guardians of minors with SUD (on adolescent units). Suggested training for staff may include effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery.
- Provide active discharge planning to next step placements based on the patient's care plan. Placements should address ongoing needs related to mental health, addiction, and other biopsychosocial needs and may include step down to subacute levels of care, 24 hour settings, partial hospitalization, intensive outpatient, ongoing outpatient treatment, access to peer services, and other community and housing supports as appropriate. When appropriate, discharge planning must include access to ongoing medication management, both for psychiatric and addiction medications; for continuity of treatment with the goal of reducing readmissions and the likelihood of relapse. This includes having knowledge of Clinical Stabilization/Stepdown Services (CSS) and Transitional Support Services (TSS), Outpatient Medication Management, Sober Houses, and step down to subacute level of care.
- Understand deterrents to successful discharges such as housing, financial assistance for medication copayments, transportation to non-24-hour programs, applying for a prescription for transportation PT-1 form for those with financial issues, etc.
- Ensure a physician dispenses buprenorphine or morphine at discharge or a DATA-waived practitioner provides "bridge" prescriptions for buprenorphine (and other medications) until outpatient appointments can be secured and prescriptions provided for in the outpatient setting.
- Provide direct care staff with a general overview of addictions medicine.

Each inpatient psychiatric facility is recommended to:

- Facilities are strongly encouraged to provide access to all FDA-approved medications for the treatment of opioid use disorder.
- Consider engaging Substance Use Recovery Coaches and/or Peer Specialists within staffing models.
- Include credentialed staff with experience in SUD treatment and resources, ideally, but not necessarily as Licensed Alcohol and Drug Abuse Counselor (LADC) or Certified Alcohol and Drug Abuse Counselor (CDAC) levels.
- Consider referrals to ensure a continuum of care for the client, including arrangements for further substance abuse treatment and post-discharge counseling and other supportive service.
- Consider entering into formal agreements (Qualified Services Organization Agreement - QSOA's) with community-based Substance Use Disorder treatment providers to support continuation of care.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have

[5] The Drug Addiction Treatment Act (DATA) of 2000 authorized physicians to dispense or prescribe buprenorphine in settings other than an opioid treatment program (OTP), subject to certain limitations. This has subsequently been expanded to also authorize nurse practitioners and physician assistants to dispense or prescribe buprenorphine, subject to certain limitations. Information on the process for submitting a waiver to SAMHSA and the DEA can be accessed here: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

been inadequate. [See DMH Licensing Bulletin #18-01 - ***Documentation of Unit Conditions and Facility Denial of Inpatient Care*** and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

APPENDIX H - COORDINATION OF BENEFITS REQUIREMENTS

The following describes the activities and requirements for ensuring that all eligible Enrollees are appropriately enrolled into the Contractor's Plan.

The Contractor shall designate a Third Party Liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract.
The Benefit Coordinator will be responsible for meeting with EOHHS when deemed necessary by EOHHS's Benefit Coordination and Recovery Unit.

I. Third Party Health Insurance Identification and Cost Avoidance

The Contractor shall develop procedures and train its staff to ensure that Enrollees who have other insurance are either (1) not enrolled into the Contractor's Plan if third party health insurance is identified and verified prior to enrollment, or (2) disenrolled by EOHHS upon third party health insurance verification post enrollment. The two most common types of third party health insurance are the Contractor's own commercial product or a third party commercial health insurance product.

Once an Enrollee is identified as having other health insurance, the Contractor must cost avoid claims for which another insurer may be liable, except in the case of prenatal and EPSDT services per 42 USC 1396a(a)(25)(E) and 42 CFR 433.139.

If the Enrollee is found to be enrolled in the Contractor's commercial plan, the Enrollee's information shall be sent to EOHHS or its designee. If the Contractor's commercial health insurance product is the other insurance, EOHHS shall disenroll the Enrollee from the Contractor's Plan effective the "TPL effective date" in MMIS.

The Contractor shall identify and communicate with EOHHS or its designee the existence of other health insurance through the following methods and procedures:

A. The Contractor shall require their Providers to send any other health insurance information found about its Enrollees to the Contractor.

B. The Contractor shall provide a TPL Indicator form, approved by EOHHS, as set forth in Appendix A, to their Providers for use in communicating to the Contractor the liable third party insurance information for their Enrollees. This form may be distributed at network trainings performed by the Contractor.

C. The Contractor shall submit such TPL information through an electronic process, as further specified by EOHHS.

D. The Contractor shall review claims data received from their Providers for indications of other liable insurance coverage. The Contractor shall send the other health insurance information to EOHHS or its designee.

II. Third Party Health Insurance Recovery

A. The Contractor shall implement procedures to (1) determine if a potential Enrollee has other health insurance and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:

1. The HIPAA 834 Outbound Daily file ;
2. Claims Activity;
3. Point of Service Investigation (Customer Service, Member Services and Utilization Management); and
4. Any TPL information self-reported by an Enrollee.

B. At a minimum, such procedures shall include:

1. Performing a data match against the Contractor's subscriber/member list for any other product line it offers and providing this information to EOHHS or its designee; and
2. Reviewing claims for indications that other insurance may be active (e.g., explanation of benefit attachments or third party payment).

C. If a claim is processed for payment and it is later determined that another carrier should have been the primary payer, the Contractor shall give the Provider the other insurance information the Contractor obtained through data matching Enrollees. The Contractor shall work with the Provider to ensure that this information is used for any further billing of claims for said Enrollee. In addition, the Contractor shall pursue recoveries for previously paid claims by sending an EOHHS approved notice of overpayment to the Provider.

D. The Contractor may recover overpayments, for dates of service not to exceed twenty-four (24) months, only after giving the Provider proper notice, including information regarding the third party carrier, and 45 calendar days to identify and address allegations in the overpayment notice with which the Provider disagrees.

E. The Contractor shall proceed with recouping overpayment for the amount paid to the Provider unless acceptable documentation (e.g., an Explanation of Payments (EOP) statement, denial from the other insurer, etc.) proving that these payments should not be recouped is received from the Provider **within forty-five calendar days** of the date of the notice of overpayment.

F. For claims that the Provider does not respond to, the Contractor may retract claims and recover overpayments 60 calendar days from the date of the notice

III. Reporting

The Contractor shall develop, at a minimum, the report identified in **Appendix A**. The Contractor shall meet with EOHHS to clarify the content of the semi-annual report listed below:

A. Health Insurance Referrals – the number of members identified as having TPL on the HIPAA 834 Outbound Full file.

B. Cost avoidance – Claims that were denied due to the existence of another health insurance plan on a monthly and semi-annual basis. The dollar amount per Member that was cost avoided on the denied claim.

C. Recovery – Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan. The dollar amount recovered per Member from the other liable insurance carrier or Provider.

IV. Accident and Third Party Liability Identification and Recovery

A. Identification

1. Claims Editing

   The Contractor shall have claims editing and reporting procedures in place to identify potential accident and casualty cases, including but not limited to the following:

   Screening Diagnosis Codes for Trauma. The Contractor shall identify Enrollees who are suspected of having suffered an injury as a result of an accident or other loss. Enrollees' names are pulled from the claims system using an automated system of selection and retrieval. The selection criterion is based on a predetermined diagnosis code range of all claims sent to the Contractor. The Contractor shall verify that an accident occurred either by contacting the Enrollee or by using an information data warehouse.

2. Sharing of TPL Information/Accident Referrals

   If the Contractor receives claims information from their Providers indicating that certain medical services are being provided as a result of an accident or other loss, the Contractor shall require their Providers to furnish all necessary information that will allow the Contractor to pursue the Accident/Recovery or Cost Avoidance.

B. Accident/Casualty Recovery and Cost Avoidance of Claims

The Contractor shall perform the following activities to recover or cost-avoid claims where an Enrollee has been involved in an accident or lawsuit.

1. Cost-Avoidance

   The Contractor shall have the following processes in place to cost avoid claims, except in the case of prenatal and EPSDT services where the Contractor shall pay and recover later per 42 USC 1396a(a)(25)(E) and 42 CFR 433.139.

   a. On all automobile cases, providing the Enrollee cooperates with the Contractor and signs the necessary paperwork, the Contractor shall process accident claims for payment and submit insurance claims to the no-fault carrier for the $8,000 PIP (personal injury protection) benefit. If possible, cases involving PIP should be cost avoided up front. After the $8,000 is exhausted, the Contractor becomes the primary payer for any future services, unless there is other third party insurance available.

   b. Claims are denied for Enrollees who do not provide the Contractor with the necessary automobile information when it has been noted that an Enrollee has been involved in an automobile accident.

   c. On all workers' compensation cases, the Contractor shall contact the employer to verify that an injury is work related, and also contact the worker's compensation carrier to determine whether the case has been accepted. All claim information is then entered into the system. If liability has been established, then the Contractor retracts all claims that relate to the accident and sends a letter to the Provider detailing the claims being retracted and whom to bill. If the case has not been accepted, then the Contractor takes appropriate steps to lien the case if necessary.

   d. Any referral entered into the system that may be trauma related is flagged in a way that prompts the Claims department to pend the claim to the Recovery Department for review.

2. Recovery

   If the Enrollee cooperates and supplies the Contractor with the necessary information, subrogation claims are processed for payment and a lien is filed on the case.

   a. If the accident is work related:

      Upon discovery that the worker's compensation case is not an accepted case, meaning that liability has not been established, and given that the Enrollee cooperates and supplies the Contractor with the necessary information, subrogation claims are processed for payment and a lien is filed on the case.

   b. Other accidents or losses (i.e., general liability, medical malpractice, etc.):

If the Enrollee cooperates and supplies the Contractor with the necessary information, subrogation claims are processed for payment and a lien is placed on the case.

3. Reporting

On a semi-annual basis, the Contractor shall provide EOHHS with an ongoing status report on all Enrollees identified as having had an accident or other loss. The report shall include the following information for each Enrollee who has been identified as receiving medical services as the result of an accident, injury, or has filed a lawsuit related to an accident or injury.

a. General Information

(1) Enrollee name;
(2) Enrollee's MassHealth or SSN number;
(3) Date of referral to EOHHS;
(4) Date of accident;
(5) Type of accident; and
(6) Status (i.e., lien, cost avoided)

b. Cost Avoidance: amount cost avoided (i.e., PIP payments)

c. Recovery

(1) Recovery Source
(2) Amount of lien;
(3) Amount of settlement (if available);
(4) Amount collected (if available); and
(5) Amount compromised.

See **Appendix A** for a sample of the required report to be sent to EOHHS.

4. EOHHS Recovery

In the event that the Contractor fails to make a subrogation claim and place a lien on the case, EOHHS, through the Massachusetts Department of Revenue's Payment Intercept Program (PIP), shall recover costs related to the Enrollee's care per M.G.L. c. 175 §24D and §24E.

V. TPL Recoveries Factored into Capitation Rate Development

EOHHS expects the Contractor to recover claims paid to its Providers where the other insurer was primary. EOHHS will factor TPL recoveries into the annual capitation rate development process.

Appendix I – Credentialing Websites

CMS Website or Database	Go to:	What is Checked	Frequency
NPI – National Provider Identifier Verify provider's NPI 6401 required	https://npiregistry.cms.hhs.gov/	NPI Number, First Name, Last Name may be entered to verify that the provider is on the NPI database	At enrollment and revalidation and as needed for all provider types
OIG – CMS Office of Inspector General Verify exclusions 6401 required	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 and monthly for all provider types
MedFile Verify exclusions 6401 required	This file is downloaded from the DEX server. MCOs receive the files from MassHealth.	Last name, first name is 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 and monthly for all provider types
Adverse Actions Report Verify exclusions 6401 required	This file is downloaded from the DEX server. MCOs receive the files from MassHealth.	View by FEIN, last name, first name, business name, adverse action and termination program to view termination data from CMS	At enrollment, revalidation and monthly for all provider types
SAM – System for Award Management 6401 required	https://sam.gov/SAM/pages/public/searchRecords/search.jsf	Enter the provider's last name then first name to verify that the provider is not on the SAM website	At enrollment, revalidation and monthly for all provider types
Death Master File Verify a provider is not listed as deceased 6401 required	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 and revalidation for all individual providers and individuals listed on a FRDF

State Website or Database	Go to:	What is Checked	Frequency
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 and 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 and revalidation for all providers with a DEA
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 and 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 and revalidation for all provider types when there is a hit on Sam, LEIE, MedFile, OIG
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

State 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 and 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 and 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 and 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 and 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 and weekly verifications

State Website or Database	Go to:	What is Checked	Frequency
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 and weekly verifications
State of Connecticut Board Actions Validate licenses and suspensions and actions	http://www.ct.gov/dph/cwp/view.asp?a=4061andq=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 and weekly verifications Usually updated quarterly
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 and 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 and 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

State Website or Database	Go to:	What is Checked	Frequency
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 J

MMIS Interfaces with Accountable Care Partnership Plans (ACOs)

All Interfaces between an Accountable Care Partnership Plan and MMIS have been defined as batch interfaces (as opposed to transactional).

All HIPAA transactions will be in **X12 format**. All non-HIPAA interfaces will be in **XML format**

Appropriate Channels for the exchange of batch transactions include:

1. Simple Object Access Protocol (SOAP) / Web Services Description Language (WSDL) or HyperText Transfer Protocol (HTTP) Multipurpose Internet Mail Extensions (MIME);
2. Health Transaction Service (HTS) – This is a grandfathered service and shall only be used to support the daily co-pay file if an entity is unable to support SOAP or MIME;
3. Provider Online Service Center (POSC); and
4. Another method specified by EOHHS as required

Listed below is a short description of each of the interfaces between MMIS and the ACOs. Note that the terms INBOUND and OUTBOUND are used to denote the flow of data relative to MMIS. Inbound is data being sent from an ACO to MMIS, and outbound is data being sent from MMIS to an ACO. Please note that other interfaces may be required by EOHHS to facilitate the exchange of healthcare information over the course of the contract engagement.

A. Inbound Interfaces

1. Inbound Accountable Care Provider Directory

   On a monthly basis, the Contractor shall submit to MMIS a full listing of its Primary Care Provider Network to be loaded into an Accountable Care Provider directory database. This database will be used to support Member enrollment choices. Information such as the provider type and specialties, working hours, languages spoken and handicap accessibility will be supplied to Enrollees based on the information in the directory.

   This file may include additional specialties as further directed by EOHHS.

2. Daily Inbound Copay File

   On a daily basis, the Contractor shall transmit co-pay information on Enrollees to MMIS in a form and format specified by EOHHS.

3. PCP Interface

   On a monthly basis, the Contractor shall submit to MMIS a list of their Primary Care Practice PID/SLs and the Enrollees empaneled there.

B. Outbound Interfaces

1. Outbound Accountable Care Provider Directory Error File

   On a monthly basis, upon receiving an inbound Accountable Care Provider Directory file, MMIS will transmit an error file composed of all inbound records that errored, and the error reason.

2. PCP Interface Error File

   On a monthly basis, upon receiving an inbound PCP Interface file, MMIS will transmit an error file composed of all inbound records that errored, and the error reason.

3. HIPAA 834 Outbound Daily File

   On a daily basis, MMIS will transmit the HIPAA 834 enrollment transactions to the Contractor. The 834 is the mechanism by which MMIS communicates to ACOs any changes in Enrollee name, DOB, gender, address, Medicare, enrollment dates and member enrollment changes.

4. HIPAA 834 Outbound Monthly File

   On a monthly basis, MMIS will transmit a full set of all enrollment transactions to the Contractor. This gives the Contractor a mechanism to verify that its enrollment files and MMIS enrollment files are synchronized. This audit file will send the most current information available which will include any Enrollee updates that took place during the previous month.

5. HIPAA 820 File

   On a scheduled monthly basis, MMIS will transmit HIPAA 820 payment confirmations.

6. Daily Outbound Copay File

   On a daily basis, MMIS will transmit copay accumulation information on Enrollees to the Contractor via the Daily Outbound Copay File**.** The file will communicate the Enrollees' monthly copay cap and their updated copay accumulations on a daily basis.

7. Monthly Outbound Copay File

   On a monthly basis, MMIS will transmit a file to report member copay amounts.

Appendix K: Primary Care Sub-Capitation Program

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

EXHIBIT 1: Practice Tier Designation Attestation

SECTION I: Instructions

The Contractor shall collect and at all times shall maintain a copy of the **Practice Tier Designation Attestation** for **each of its Network Primary Care Practice PID/SLs (ACPP) or Participating Primary Care Practice PID/SLs (PCACO)**, signed by the Contractor and an authorized representative of the Network/Participating Primary Care Practice PID/SL. The Contractor shall provide EOHHS with such copies upon request.

Each Network Primary Care Practice PID/SL or Participating Primary Care Practice PID/SL shall have a single, unique Tier Designation. For the purposes of the Primary Care Sub-Capitation Program, "Practice" shall mean a Network Primary Care Practice PID/SL's or Participating Primary Care Practice PID/SL's unique, 10-digit alpha-numeric Provider ID Site Location (PID/SL) that is unique to a location. With the exception of sole practitioners operating independently, the Primary Care Practice PID/SL shall *not* be unique to a practitioner.

Requirements for Tier Designation

(1) Practices with Tier 1 designation must fulfill **all** Tier 1 care model requirements by July 1, 2023
(2) Practices with Tier 2 designation must fulfill **all** Tier 1 and Tier 2 care model requirements by July 1, 2023
(3) Practices with Tier 3 designation must fulfill **all** Tier 1, 2, and 3 care model requirements by July 1, 2023

SECTION II: Practice Information

Practice Name	
Practice Street Address	
Practice City	
Practice State	
Practice Zip Code	
Practice Tax ID	
Practice MassHealth Provider ID Site/Location (PID/SL)	
Name of Authorized Practice Representative	
Practice Representative Phone Number	
Practice Email	
Proposed Tier Designation (1, 2, or 3)	

SECTION III: Practice Attestation

1. The practice substantially serves (check one or both):

   ☐ Enrollees ages 21-65 (i.e., Family Medicine or Adult)

   ☐ Enrollees ages 0-21 (i.e., Family Medicine or Pediatric)

2. The practice will meet all criteria by July 1, 2023, as specified in Exhibit 2 of this Appendix, of:

   ☐ Tier 1

   ☐ Tier 2

   ☐ Tier 3

3. The practice is not contracted as a Network PCP (ACPP) or Participating PCP (PCACO) for any other MassHealth ACO or MCO, and is not a PCC in the PCC Plan.

   ☐ Check here to agree

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

_____

Printed legal name of authorized Contractor representative

_____

Contractor representative's signature Date

_____

Printed legal name of Practice representative

_____

Practice representative's signature Date

EXHIBIT 2: Primary Care Sub-Capitation Program Tier Criteria

SECTION I: Tier 1 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 1. Practices shall meet ***all*** Tier 1 requirements to achieve this Tier Designation. Some requirements must be accessible to Enrollees on-site if the Enrollee so chooses, without leaving the practice building, and some requirements may be met exclusively via a central or virtual resource, including being provided by the ACO, as indicated in each requirement description.

A. Care Delivery Requirements

Practices shall:

☐ Traditional primary care: provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Referral to specialty care: be able to guide and coordinate referrals and request evaluation of a patient by clinicians outside of the primary care practice for specific concerns. Such referrals shall include the primary care practice's ability to communicate with and receive communications from the specialty practice, with the primary care practice continuing to serve as a central home of health care services for the patient. This includes sub-specialty medical, oral health, mental health, and substance use disorder referrals.

☐ Oral health screening and referral: conduct an annual (every 12 months) structured oral health screening for attributed patients. For example, a clinic tool may use the National Health and Nutrition Examination Survey Oral Health Questionnaire (https://wwwn.cdc.gov/nchs/data/nhanes/2015-2016/questionnaires/OHQ_I.pdf). An on-site dental exam for attributed patients shall meet this requirement. An assessment screening shall clearly define what constitutes a positive screening result versus a negative result and shall assess if the patient currently has access to an oral health provider or a regular and reliable source for oral health needs.

Additionally, retain and provide to patients (and/or their parents/caregivers) a list of local and reasonably-accessible oral health providers who are within the MassHealth network for their particular patients (MassHealth providers are available at: https://provider.masshealth-dental.net/MH_Find_a_Provider#/home). This information shall be updated at least annually for any openings/closings or additions/removals of MassHealth coverage of these providers. Such a list shall be provided to patients with a positive oral health screen and those without an oral health provider. Such a list may be adapted from materials provided by MassHealth of practices and providers currently enrolled in the program.

While practices may offer some oral health screenings and referrals virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Behavioral health (BH) and substance use disorder screening: conduct an annual and universal practice-based screening of attributed patients ≥21 years of age. Such a screen shall at minimum assess for depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting

mental health disorders using an age-appropriate, evidence-based, standardized screening tool. When any screening is positive, the practice shall respond with appropriate interventions and/or referrals.

See below under this Section 1, subsection C for screening expectations for any attributed patients younger than 21 years of age per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocol and schedule.

While practices may offer some BH and substance use screening virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ BH referral with bi-directional communication, tracking, and monitoring: retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs. The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other. The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times.

In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit.

☐ BH medication management: prescribe, refill, and adjust medications for the treatment of common BH issues amenable to treatment in the primary care setting, including but not limited to major depressive disorder, generalized anxiety disorder, and attention deficit-hyperactivity disorder. Such services can occur independently or providers may receive assistance from available resources such as the Massachusetts Child Psychiatry Access Program (MCPAP), a clinical pharmacist, psychiatrist, psychiatric clinical nurse specialist, etc. While practices may offer some BH medication management virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Health-Related Social Needs (HRSN) screening: conduct universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool, and shall have the ability to provide a regularly-updated inventory of relevant community-based resources to those with positive screens. Pediatric screening questions shall be reviewed by the ACO's designated Pediatric Expert. HRSN screening may be met exclusively via a central or virtual resource, including being provided by the ACO.

☐ Care coordination: participate in formalized practice-driven and/or ACO-driven care coordination that identifies patients at risk due to medical, BH, HRSN, psychosocial and/or other needs and deploys risk-stratified interventions and approaches to addressing patients' needs.

Such approaches can include but are not limited to communication and information-sharing between care team patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, pre-visit planning, post-hospitalization coordination, and assistance with patient self-management of chronic disease. Such approaches can also include connecting patients to community-based services, state agencies (e.g., Massachusetts Department of Children and Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of

Mental Health [DMH], Massachusetts Department of Public Health [DPH], Massachusetts Department of Transitional Assistance [DTA], Massachusetts Department of Youth Services [DYS]), federal programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC]), other ACO programs such as the ACO Care Management, Community Partners and Flexible Services programs, and other supports and care management resources.

These services may be provided by practice-based personnel directly, or by ACO- or system-level resources and care pathways that coordinate with the primary care practice. Such interventions shall be standardized and consistent workstreams for the practice and align with the greater ACO's strategies around physical health, BH, HRSN, and other care coordination.

For more information on ACO expectations around care coordination, please refer to Section 2.6 of the Contract. Care coordination may be met exclusively via a central or virtual resource, including being provided by the ACO.

☐ Clinical Advice and Support Line: Ensure patients are made aware of the availability of after-hours telephonic advice, either through the ACO's Clinical Advice and Support Line, or a resource provider by the practice. Clinical advice and support line services may be met exclusively via a central or virtual resource, including being provided by the ACO.

☐ Postpartum depression screening: If caring for infants in the first year of life or for postpartum individuals who are within 12 months of delivery, screen for postpartum depression using an evidence-based and validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS).

For individuals who have a positive screen for postpartum depression, the practice shall be able to provide referral, or follow-up, and/or care coordination for the patient. Care coordination models shall be evidence-based (examples of such models include PRISM - Program In Support of Moms and ROSE - Reach Out Stay Strong Essentials for mothers of newborns). While practices may offer some postpartum depression screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Use of Prescription Monitoring Program: All prescribing personnel at the practice site shall have access to and regularly use the Massachusetts Prescription Awareness Tool (Mass PAT) in accordance with Commonwealth of Massachusetts General Law: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section24A.

☐ Long-Acting Reversible Contraception (LARC) provision, referral option: have the ability to discuss options for LARC (e.g., intrauterine device or subdermal implant) with relevant patients and refer patients seeking such options to known in-network providers who can place these for the patient. Providers may also, rather than referring patients, provide and place these directly for patients within the primary care practice.

B. Structure and Staffing Requirements

Practices shall:

☐ Same-day urgent care capacity: make available time slots each day for urgent care needs for its patient population. While practices may offer some urgent care capacity virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Video telehealth capability: have the ability to conduct visits with practice staff using a synchronous audio-video telehealth modality in lieu of an in-person patient encounter.

☐ No reduction in hours: Relative to regular practice hours prior to engagement in the sub-capitation program, offer the same or increased number of total regular on-site operating hours and clinical sessions in which patients have been historically seen.

☐ Access to Translation and Interpreter Services: provide interpreter services for attributed patients, in accordance with applicable state and federal laws, including options to accommodate preferred languages and the needs of enrollees who are deaf or hard of hearing. Such services shall be noted to be available in a patient's or their caregiver's preferred language and should come without additional cost to the patient.

C. Population-Specific Requirements

Practices serving Enrollees 21 years of age or younger shall:

☐ Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT. While practices may offer some EPSDT screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Screen for SNAP and WIC eligibility, in accordance with Provider Manual Appendix W, if applicable: Practices shall also complete the medical referral form for WIC eligible patients. Patients and families deemed eligible for these programs should be referred to further resources in order to apply for and engage these programs. While practices may offer some SNAP and WIC screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI): The practice shall identify its staff member(s) responsible for 1) communicating with and reporting to CBHI program in a closed-loop manner, and 2) maintaining a roster of children attributed to the practice who are receiving CBHI services.

☐ Coordination with MCPAP: enroll with MCPAP at https://www.mcpap.com/. The practice shall consult with and use the services of MCPAP to augment the BH expertise provided within the practice as a means to maintain the management of youth with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with child and adolescent psychiatrists working in the clinic or a neighboring site or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource, however, does not exempt the practice from enrolling with MCPAP.

☐ Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M): If providing obstetrical services, enroll in the M4M program at https://www.mcpapformoms.org/. The practice shall consult with M4M to augment the BH expertise provided within the practice as a means to maintain the management of perinatal patients with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with a psychiatrist or appropriately trained Ob/Gyn of suitable expertise working in the clinic or a neighboring site, or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource however

does not exempt the practice from enrolling with the M4M program. While practices may offer some coordination with MCPAP for Moms virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Fluoride varnish for patients ages 6 months up to age 6: assess the need for fluoride varnish at all preventive visits from six (6) months to six (6) years old, and, once teeth are present, must provide application of fluoride varnish on-site in the primary care office at least twice per year for all children, starting when the first tooth erupts and until the patient has another reliable source of dental care (https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary). For those pediatric patients who do not have a dental home, the practice must share a list of MassHealth dental providers with the parent/caregiver as noted above. If there is a co-located dental office or evidence that the dental office has already provided this service, such may substitute in this requirement for the relevant patients who have access to or have accessed these resources. Enrollees must be able to access this fluoride varnish on-site.

There is no buprenorphine requirement for Tier 1 practices serving Enrollees under age 21.

Practices serving Enrollees ages 21-65 shall:

☐ Buprenorphine Waivered Practitioner Requirement: All individual Primary Care Providers must have the capability and credentialing to prescribe buprenorphine. This requirement can be met by prescribers either submitting the Substance Abuse and Mental Health Services Administration (SAMHSA) notice of intent (NOI) without additional training requirements, or via having a buprenorphine waiver. More information can be found here. The individual providers need not be actively prescribing buprenorphine to meet this requirement.

SECTION II: Tier 2 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 2. Practices shall meet ***all Tier 1 requirements and all Tier 2 requirements*** to achieve this Tier Designation.

A. Care Delivery

The practice shall:

☐ Brief intervention for BH conditions: Provide brief interventions for patients with identified BH needs, as appropriate, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), brief Cognitive Behavioral Therapy (CBT), or an equivalent model. These may be provided by a front-line clinical provider or by an integrated member of the clinical team, such as a licensed independent clinical social worker (LICSW). While practices may offer some BH interventions for BH conditions virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Telehealth-capable BH referral partner: Include at least one BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network.

B. Structure and Staffing

The practice shall:

☐ E-consults available in at least three (3) specialties: be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the practice to discuss with specialists in at least three distinct and non-redundant American Board of Medical Specialties (ABMS)-recognized specialties. For example, offering e-consults to multiple specialties with board certification under the pathways of Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, seeking to count e-consults in general cardiology, clinical cardiac electrophysiology, and interventional cardiology as three distinct specialties would not meet this requirement.

☐ After-hours or weekend session: offer at least four hours for in-person or telehealth visits, with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, at least once per week within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice for this coverage, EOHHS encourages the Contractor to utilize practices that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

☐ Team-based staff role: maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles:

- Community health worker (CHW)
- Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
- Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
- Nurse case manager

Such team-based role shall:

- Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., ≥0.3 FTE) per week,
- Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

☐ Maintain a consulting independent BH clinician: maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above.

- This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care.
- This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two business days.

C. Population Specific Expectations

Practices serving Enrollees 21 years of age or younger shall:

☐ Staff with children, youth, and family-specific expertise: identify at least one non-clinical team member with demonstrable experience addressing the BH and HRSN of children, youth, and families in a health care setting and/or possessing specialized training, degree, licensing, or certification in such work. This role may be met virtually but shall be on-site at least monthly. This role shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, Family Resource Centers (FRCs), and schools/early childhood settings.

☐ Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site.

☐ Buprenorphine Waivered Practitioner Requirement: At least one (1) individual Primary Care Provider at the practice must have the capability and credentialing to prescribe buprenorphine. This requirement can be met by prescribers either submitting the Substance Abuse and Mental Health Services Administration (SAMHSA) notice of intent (NOI) without additional training requirements, or via having a buprenorphine waiver. More information can be found here. The individual Primary Care provider with the capability and credentialing to prescribe buprenorphine need not be actively prescribing buprenorphine to meet this requirement.

Providers may leverage the partnership and guidance of MCPAP for guidance on prescribing buprenorphine: www.mcpap.com.

Practices serving Enrollees ages 21-65 shall:

☐ LARC provision, at least one option: have the on-site ability to place at least one (1) type of long-acting reversible contraceptive (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). This activity may occur either in the primary care office or from a co-located provider at the same practice site. Enrollees must be able to access this requirement on-site.

☐ Active Buprenorphine Availability: have at least one (1) individual provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for Enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service, without having to refer the Enrollee to another location. This provider shall be dedicated and available to patients in the practice on-site or virtually on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices that require the Enrollee to present at a different location does not meet this requirement.

☐ Active Alcohol Use Disorder (AUD) Treatment Availability: at least one provider actively prescribing or willing and able to prescribe relevant medications for management of alcohol use disorder (e.g., Disulfiram, Acamprosate, Naltrexone, etc.). This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

SECTION III: Tier 3 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 3. Practices shall meet *all Tier 1 requirements, all Tier 2 requirements, and all Tier 3 requirements* to achieve this Tier Designation.

A. Care Delivery

*The practice shall fulfill at least **one** of the following three requirements:*

☐ Clinical pharmacist visits: offer its patients the ability to conduct office-based or virtual appointments with a licensed clinical pharmacist focused on medication management and teaching. This role may conduct its activities virtually. The clinical pharmacist shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE)

OR

☐ Group visits: offer its patients the ability to participate in office-based or virtual appointments at which services are provided to multiple patients for a shared condition and peer support is elicited (e.g., mental health, substance use disorder, antenatal care, etc.). These visits may be conducted virtually. Group visits shall be offered by staff that are dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE)

OR

☐ Designated Educational Liaison for pediatric patients: For practices serving pediatric patients, have dedicated staff member that serves as an office-based or virtual resource for families navigating the intersection of the medical and educational systems. This role may conduct its activities virtually. The Educational Liaison shall have knowledge of education and special education systems, including early education settings, and shall create relationships with local schools and early education settings. The Educational Liaison shall provide support to patients with medical, developmental, and/or BH needs and shall be available to provide input to the educational team at schools as needed and shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE).

B. Structure and Staffing

The practice shall:

☐ E-consults available in at least five (5) specialties: be capable of asynchronous, consultative, provider-to-provider communications within a shared EHR or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the primary care practice to discuss with specialists in at least five (5) distinct and non-redundant ABMS-recognized specialties. For example, offering e-consults to multiple specialties with board certification under Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, general cardiology, clinical cardiac electrophysiology, and interventional cardiology would not meet this requirement.

☐ After-hours or weekend session: offer at least 12 hours for in-person or telehealth visits with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, falling within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period of at least four hours

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice site may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice site for this coverage, EOHHS encourages the Contractor to utilize practice sites that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. At least 4 hours shall be in-person. At least 4 hours must fall on a weekend day. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

☐ Three team-based staff roles: maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following:

- At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW)
- At least one (1) staff role shall be a peer, family navigator, CHW, or similar.
- The other staff role(s) may be one of the following, or similar:
  - Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
  - Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
  - Nurse case manager

Such team-based roles shall:

- Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE) individually, and at minimum collectively 1.0 FTE per the practice.
- Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- Collectively, ensure at least one (1) FTE meeting these staff roles is available and dedicated to the practice at each of the 10 usual business hour sessions (Monday through Friday, mornings and afternoons) to respond in real-time to practice needs.
- All participate in regular team activities such as team huddles (i.e., standing team meetings for the purpose of pre-visit planning), population health management, and/or process improvement

☐ Maintain a consulting BH clinician with prescribing capability: maintain a dedicated and accessible consulting BH clinician on-site or virtually with prescribing capability available to assist the practice with cases of moderate and rising complexity. Such BH clinician shall:

- Have familiarity with titration of BH medications (e.g., psychiatrist or psychiatric clinical nurse practitioner).
- Be regularly available for activities including but not limited to making appointments on behalf of the practice in the same week, participating in case management activities, answering practice queries within two (2) business days, and assisting with co-management of referred cases

C. Population Specific Expectations

Practices serving Enrollees 21 years of age or younger shall:

☐ Full-time staff with children, youth, and family-specific expertise: identify at least one non-clinical team member with experience addressing BH and HRSN of children, youth, and families in a health care setting and/or with specialized degree, license, training, or certification in such work. Such staff shall be available during normal business hours (Monday through Friday, mornings and afternoons), and shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, FRCs, and schools/early childhood education settings. This role may be met virtually but shall be on-site at least monthly.

☐ LARC provision, at least one (1) option: have the ability on-site to insert at least one type of LARC (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). Enrollees must be able to access this requirement on-site.

☐ Active Buprenorphine Availability: must have at least one (1) provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder, as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service without having to refer the Enrollee to another location. This provider shall be available to patients in the practice on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices at a different location does not meet this requirement. Providers may leverage the partnership and guidance of MCPAP for guidance on prescribing buprenorphine: www.mcpap.com. This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

Practices serving Enrollees ages 21-65 shall:

☐ LARC provision, multiple options: have the ability on-site to insert multiple forms of LARC (e.g., intrauterine device and subdermal implant). This service shall be available on-site during normal business hours at least one (1) session per week. Enrollees must be able to access this requirement on-site.

☐ Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up: must have an evidence-based written protocol (such as SAMHSA's guidance found here) and the capability to provide in-office or virtual induction (as permitted by federal law, including but not limited to the Ryan Haight Act) of buprenorphine and opioid withdrawal management within one business day of diagnosis of opioid use disorder or treatment of withdrawal or relapse.

- The MOUD induction requirement may be met virtually, including by third party entities. However, the practice must fulfill Tier 2 requirements set forth above regarding maintenance prescribing at the practice.

  Providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

SECTION IV: Acronyms & Terms Glossary

Terms

Adult practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to adults and those >21 years

	of age. An adult practice shall fulfill requirements specific to adult populations. Pediatric practices that serve a small number of adult patients are not adult practices, and do not need to meet the requirements specific to adult populations Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
E-Consult	Asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.
Family Medicine practice	Any primary care practice, either standalone or within a larger building, that provides care to patients across the lifespan. A family medicine practice shall fulfill requirements specific to both pediatric and adult populations. Each Family Medicine practice shall have a single Tier Designation
Pediatric practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to children and adolescent patients 21 years of age or younger. A pediatric practice shall fulfill requirements specific to pediatric populations. Adult practices that serve a small number of patients under age 21 are not pediatric practices, and do not need to meet the requirements specific to adult populations. Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
Session	≥4 consecutive hours of clinical work time, usually defined as a continuous morning or afternoon block of time in which providers see patients.

Acronyms

ABMS	American Board of Medical Specialties
AUD	Alcohol Use Disorder
BH	Behavioral Health
CBHI	Children's Behavioral Health Initiative
CBT	Cognitive Behavioral Therapy
CHW	Community Health Worker
DCF	Massachusetts Department of Children and Families
DDS	Massachusetts Department of Developmental Services
DMH	Massachusetts Department of Mental Health
DPH	Massachusetts Department of Public Health
DTA	Massachusetts Department of Transitional Assistance

DYS	Massachusetts Department of Youth Services
EHR	Electronic Health Record
EPDS	Edinburgh Postnatal Depression Scale
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FRC	Family Resource Centers
HRSN	Health-Related Social Needs
LARC	Long-Acting Reversible Contraception
LCSW	Licensed Clinical Social Worker
LICSW	Licensed Independent Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
M4M	Massachusetts Child Psychiatry Access Program for Moms
Mass PAT	Massachusetts Prescription Awareness Tool
MCPAP	Massachusetts Child Psychiatry Access Program
MOUD	Medication for Opioid Use Disorder
MSW	Master of Social Work
NOI	Notice of intent
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SNAP	Supplemental Nutrition Assistance Program
WIC	Special Supplemental Nutrition Assistance Program for Women, Infants, and Children

APPENDIX L

SUB-CAPITATION PROGRAM RATES FOR PRIMARY CARE ENTITIES
Contract Year 1

Listed below are the Per Member Per Month (PMPM) Primary Care Entity (PCE) Primary Care Sub-Capitation Rates, developed by EOHHS, for Contract Year 1 (Contract Operational Start Date through December 31, 2023) (also referred to as Rate Year 2023 or RY23). Please refer to **Section 2.23.A.1.h** for information on how the Contractor shall pay each PCE during the Contract Year.

PCE-specific Primary Care Sub-Capitation Rates			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
PCE (as defined by EOHHS)	**PCE SUB-CAPITATION RATE COMPONENT: BASE SUB-CAPITATION RATE**	**PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT**	**TOTAL PCE SUB-CAPITATION RATE (see Section 2.23.A.1.h)**
	(per member per month)	**(per member per month)**	**(per member per month)**
[redacted]	**$25.29**	**$4.94**	**$30.23**
[redacted]	**$14.09**	**$4.97**	**$19.05**
[redacted]	**$22.19**	**$4.97**	**$27.16**
[redacted]	**$19.70**	**$4.95**	**$24.65**
[redacted]	**$21.70**	**$4.98**	**$26.68**
[redacted]	**$23.20**	**$4.96**	**$28.16**
[redacted]	**$21.87**	**$4.95**	**$26.82**
[redacted]	**$27.48**	**$4.99**	**$32.47**
[redacted]	**$21.65**	**$4.96**	**$26.61**
[redacted]	**$18.66**	**$4.90**	**$23.56**
[redacted]	**$19.12**	**$4.97**	**$24.09**
[redacted]	**$17.70**	**$5.00**	**$22.70**
[redacted]	**$22.89**	**$4.97**	**$27.86**
[redacted]	**$26.16**	**$4.97**	**$31.13**
[redacted]	**$32.22**	**$4.97**	**$37.19**
[redacted]	**$28.92**	**$4.87**	**$33.79**
[redacted]	**$23.08**	**$4.96**	**$28.04**

PCE-specific Primary Care Sub-Capitation Rates			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
PCE (as defined by EOHHS)	PCE SUB-CAPITATION RATE COMPONENT: BASE SUB-CAPITATION RATE (per member per month)	PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT (per member per month)	TOTAL PCE SUB-CAPITATION RATE (see Section 2.23.A.1.h) (per member per month)
[redacted]	$20.58	$4.96	$25.54
[redacted]	$27.88	$4.97	$32.85
[redacted]	$16.11	$4.94	$21.06
[redacted]	$22.13	$4.98	$27.11
[redacted]	$21.01	$4.96	$25.97
[redacted]	$24.28	$4.95	$29.22
[redacted]	$24.61	$4.98	$29.59
[redacted]	$23.55	$4.97	$28.52
[redacted]	$21.05	$4.96	$26.01
[redacted]	$16.18	$4.96	$21.14
[redacted]	$17.56	$4.96	$22.51
[redacted]	$15.00	$4.95	$19.95
[redacted]	$22.96	$4.93	$27.89
[redacted]	$21.50	$4.99	$26.49
[redacted]	$25.48	$4.97	$30.45
[redacted]	$23.93	$4.97	$28.90
[redacted]	$20.35	$4.97	$25.32
[redacted]	$16.21	$4.94	$21.15
[redacted]	$20.86	$4.95	$25.81
[redacted]	$18.81	$4.98	$23.79
[redacted]	$22.38	$4.97	$27.35
[redacted]	$22.99	$4.98	$27.97
[redacted]	$21.33	$4.98	$26.31
[redacted]	$22.66	$4.95	$27.61
[redacted]	$21.04	$4.99	$26.04
[redacted]	$20.53	$4.99	$25.52

PCE-specific Primary Care Sub-Capitation Rates			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
PCE (as defined by EOHHS)	PCE SUB-CAPITATION RATE COMPONENT: BASE SUB-CAPITATION RATE (per member per month)	PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT (per member per month)	TOTAL PCE SUB-CAPITATION RATE (see Section 2.23.A.1.h) (per member per month)
[redacted]	$19.42	$4.99	$24.41
[redacted]	$25.26	$4.98	$30.24
[redacted]	$22.10	$4.96	$27.05
[redacted]	$25.36	$4.96	$30.32
[redacted]	$22.69	$4.98	$27.67
[redacted]	$24.71	$4.97	$29.69
[redacted]	$18.84	$4.98	$23.82
[redacted]	$20.31	$4.98	$25.28
[redacted]	$19.28	$4.98	$24.26
[redacted]	$23.35	$4.97	$28.31
[redacted]	$16.52	$4.97	$21.49
[redacted]	$19.60	$4.98	$24.58
[redacted]	$16.80	$4.94	$21.74
[redacted]	$17.65	$4.97	$22.63
[redacted]	$17.16	$4.99	$22.16
[redacted]	$14.91	$4.94	$19.85
[redacted]	$28.86	$4.98	$33.85
[redacted]	$23.46	$4.96	$28.42
[redacted]	$17.94	$5.00	$22.94
[redacted]	$22.52	$4.98	$27.49
[redacted]	$20.57	$4.99	$25.56
[redacted]	$21.75	$4.98	$26.72
[redacted]	$11.51	$4.97	$16.48
[redacted]	$19.82	$4.94	$24.76
[redacted]	$21.01	$5.00	$26.01
[redacted]	$29.50	$4.96	$34.47

PCE-specific Primary Care Sub-Capitation Rates			
Effective Contract Operational Start Date – December 31, 2023 (RY23)			
PCE (as defined by EOHHS)	**PCE SUB-CAPITATION RATE COMPONENT: BASE SUB-CAPITATION RATE**	**PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT**	**TOTAL PCE SUB-CAPITATION RATE (see Section 2.23.A.1.h)**
	(per member per month)	**(per member per month)**	**(per member per month)**
[redacted]	**$23.48**	**$4.98**	**$28.46**
[redacted]	**$19.52**	**$4.95**	**$24.47**
[redacted]	**$25.17**	**$4.96**	**$30.13**
[redacted]	**$32.54**	**$4.98**	**$37.52**
[redacted]	**$29.40**	**$4.96**	**$34.36**
[redacted]	**$21.17**	**$4.91**	**$26.08**
[redacted]	**$18.15**	**$4.95**	**$23.10**
[redacted]	**$23.99**	**$4.98**	**$28.97**
[redacted]	**$23.24**	**$5.00**	**$28.24**

Appendix M - Flexible Services Program

Flexible Services Enrollee Eligibility and Allowable Services

A. The Contractor shall ensure that Enrollees receiving any services that are paid for using Flexible Services funding are:

1. Eligible for MassHealth and enrolled with the Contractor on the following days:

    a. On the date the Flexible Services screening is conducted;

    b. On the first date of a Flexible Services episode of care, which is a set of related Flexible Services (e.g., tenancy sustaining supports, home modifications, nutrition sustaining supports); and

    c. Every subsequent 90 calendar days from the initial date of service for the Flexible Service episode of care until the conclusion of that episode.

2. Have been assessed by the Contractor to meet at least one health needs based criteria and one risk factor, described as follows:

    a. Health Needs Based Criteria:

        i. The individual is assessed to have a behavioral health need (mental health or substance use disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support); or

        ii. The individual is assessed to have a complex physical health need, which is defined as persistent, disabling, or progressively life-threatening physical health condition(s), requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support); or

        iii. The individual is assessed to have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs); or

        iv. The individual has repeated incidents of emergency department use (defined as 2 or more visits within six months, or 4 or more visits within a year); or

        v. The individual is pregnant and experiencing high risk pregnancy or complications associated with pregnancy, including:

a) Individuals 1 year postpartum;

b) Their children up to one year of age; and

c) Their children born of the pregnancy up to one year of age.

b. Risk Factors:

i. Risk Factor 1: The Enrollee is experiencing homelessness, as defined by the following:

a) An individual, including individual Enrollees that are part of a family unit, who lacks a fixed, regular, and adequate nighttime residence, meaning:

(i) An individual with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(ii) An individual living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or

(iii) An individual who is exiting an institution where they resided for 90 days or less and who is experiencing Risk Factor 1 (1)(a) or Risk Factor 1 (1)(b);

b) An individual, including individual Enrollees that are part of a family unit, who will imminently lose their primary nighttime residence, provided that:

(i) The primary nighttime residence will be lost within 21 days of the date of verification of Flexible Services eligibility as outlined in Appendix M.2

(ii) No subsequent residence has been identified; and

(iii) The individual lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

c) Any individual, including individual Enrollees that are part of a family unit, who:

(i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, unsafe, or life-threatening conditions that relate to violence, including physical or emotional, against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to or stay in their primary nighttime residence;

(ii) Has no other residence; and

(iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

ii. Risk Factor 2: The Enrollee is at risk of homelessness as defined by the following:

a) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation or a safe haven; and

b) Meets one of the following conditions:

(i) Has moved because of economic reasons two or more times during the 60 days immediately preceding the date of verification of Flexible Services eligibility as outlined in Appendix M.2

(ii) Is living in the home of another person because of economic hardship;

(iii) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, state, or local government programs for low-income individuals;

(iv) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room;

(v) Has a past history of receiving services in a publicly funded institution, or system of care (such as a health-care facility,

a mental health facility, foster care or other youth facility, or correction program or institution); or

(vi) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness. Characteristics are defined as:

(vii) Living in housing that is unhealthy (e.g., the presence of any characteristics that might negatively affect the health of its occupants, including, but not limited to, evidence of rodents, water leaks, peeling paint in homes built before 1978, absence of a working smoke detector, and/or poor air quality from mold or radon).

(viii) Living in housing that is inadequate as defined as an occupied housing unit that has moderate or severe physical problems (e.g., deficiencies in plumbing, heating, electricity, hallways, and upkeep). Examples of moderate physical problems in a unit include, but are not limited to, two or more breakdowns of the toilets that lasted more than 6 months, unvented primary heating equipment, or lack of a complete kitchen facility in the unit. Severe physical problems include, but are not limited to, lack of running hot or cold water, lack of a working toilet, and exposed wiring.

(ix) Rent Arrears (1 or more): Missing one or more monthly rent payment as well as situations such as receiving a Notice to Quit, being referred to Housing Court, receiving complaints from a property manager/landlord, or failure to have one's lease recertified or renewed

iii. Risk Factor 3: The Enrollee is at risk for nutritional deficiency or nutritional imbalance due to food insecurity, defined as having limited or uncertain availability of nutritionally adequate, medically appropriate, and/or safe foods, or limited or uncertain ability to acquire or prepare acceptable foods in socially acceptable ways. Limited or uncertain is defined as:

a) Reduced quality, variety, or desirability of diet with little or no indication of reduced food intake; or

b) Multiple indications of disrupted eating patterns and reduced food intake.

B. Allowable Flexible Services [1]

The Contractor shall only provide Flexible Services as specified below:

1. Pre-Tenancy Supports – Individual Supports must be one or more of the following:

    a. Assessing and documenting the member's preferences related to the tenancy the member seeks, including the type of rental sought, the member's preferred location, the member's roommate preference (and, if applicable, the identification of one or more roommates), and the accommodations needed by the member

    b. Assisting the member with budgeting for tenancy/living expenses, and assisting the member with obtaining discretionary or entitlement benefits and credit (e.g., completing, filing, and monitoring applications to obtain discretionary or entitlement benefits and credit as well as obtaining or correcting the documentation needed to complete such applications)

    c. Assisting the member with obtaining, completing, and filing applications for community-based tenancy

    d. Assisting the member with understanding their rights and obligations as tenants

    e. Assisting the member with obtaining services needed to establish a safe and healthy living environment

    f. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed

2. Pre-Tenancy Supports – Transitional Assistance includes:

    a. Assisting the member with obtaining and/or providing the member with one-time household set-up costs and move-in expenses, incurred during the transition period and the surrounding time, including, but not limited to:

        i. First and last month's rent

        ii. Security deposit

        iii. Back utilities

[1] Allowable Services subject to change pending CMS approval

iv. Utility deposits (e.g., electricity, gas, heating fuel, water, sewer)

v. Costs for filing applications

vi. Obtaining and correcting needed documentation

vii. Purchase of household furnishings needed to establish community-based tenancy

b. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed

3. Tenancy Sustaining Supports

a. Assisting the member with communicating with the landlord and/or property manager regarding the member's disability, and detailing the accommodations needed by the member

b. Assisting the member with the review, update, and modification of the member's tenancy support needs, as documented in the member's FS Plan, on a regular basis to reflect current needs and address existing or recurring barriers to retaining community tenancy

c. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit, including, but not limited to obtaining, completing, filing, and monitoring applications

d. Assisting the member with obtaining appropriate sources of tenancy training, including trainings regarding lease compliance and household management

e. Assisting the member in all aspects of the tenancy, including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during negotiations with a landlord, and directing a member to appropriate sources of legal services

f. Assisting the member with obtaining or improving the adaptive skills needed to function and live independently and safely in the community and/or family home, including advising the member of the availability of community resources.

g. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed

4. Home Modification

Home Modifications consist of limited physical adaptations to the member's community-based dwelling, when necessary, to ensure the member's health, welfare, and safety, or to enable the member to function independently in a community-based setting. These may include, but are not limited to:

a. Installation of grab bars and hand showers

b. Doorway modifications

c. In-home environmental risk assessments

d. Refrigerators for medicine such as insulin

e. HEPA filters

f. Vacuum cleaners

g. Pest management supplies and services

h. Air conditioner units

i. Hypoallergenic mattresses and pillow covers

j. Traction or non-skid strips

k. Night lights

l. Training to use such supplies and modifications correctly

5. Nutrition Sustaining Supports

a. Assisting the member with obtaining discretionary or entitlement benefits and credit, including but not limited to completing, filing, and monitoring applications as well as obtaining and correcting the documentation needed to complete such applications

b. Assisting the member with obtaining and/or providing household supplies needed to meet nutritional and dietary need

c. Assisting or providing the member with access to foods that meet nutritional and dietary need that cannot otherwise be obtained through existing discretionary or entitlement programs

d. Assisting or providing the member with nutrition education and skills development

e. Providing healthy, well-balanced, home-delivered meals for the member

1) If the member is a child/adolescent (0-18 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household

f. Assisting the member in maintaining access to nutrition benefits including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during appeals of benefit actions (e.g., denial, reduction, or termination) and directing member to appropriate sources of legal services

g. Assisting or providing the member with obtaining transportation to any of the NSS services, or transportation supporting the member's ability to meet nutritional and dietary needs (e.g., providing a member with transportation to the grocery store)

C. The Contractor shall not use its Flexible Services Allotment funding for any of the following:

- Ongoing payment of rent or other room and board costs including, but not limited to, temporary housing, motel stays, and mortgage payments, as well as housing capital and operational expenses
- Housing adaptations to the dwelling that are of general utility, and are not of direct medical or remedial benefit to the member
- Housing adaptations that add to the total square footage of the dwelling except when necessary to complete an adaptation that is of direct medical or remedial benefit to the member (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
- Construction costs (bricks and mortar) or capital investments
- Housing adaptations that would normally be considered the responsibility of the landlord
- Cable/television/phone/internet setup or reoccurring payments
- Ongoing utility payments
- Building or purchasing new housing
- One-time rent payments to avoid eviction
- Legal representation (note, legal education, coaching, and support are allowable, but direct legal representation is not)
- Meals for an eligible member that exceed more than 3 meals a day

- Goods exceeding the necessary amount for the specific needs of the member (e.g., food vouchers that enable a member to access more food than they need).
- Infrastructure costs of the Contractor or any CPs partnering with the Contractor
- Infrastructure costs associated with a partnering SSO
- Services or goods that are available through other state, federal, or other publicly funded programs.
- Services that are duplicative of services a member is already receiving
- Services where other funding sources are available
- Supports that a member is eligible to receive under the CP Program
- Alternative medicine services
- Medical marijuana
- Copayments
- Premiums
- Gift cards or other cash equivalents with the exception of nutrition or transportation related vouchers or nutrition prescriptions
- Student loan payments
- Credit card payments
- Licenses (drivers, professional, or vocational)
- Educational supports other than those allowable under tenancy and nutrition
- Vocational training
- Childcare
- Memberships not associated with one of the allowable domains
- Social Activities
- Hobbies
- Goods and services intended for leisure or recreation
- Clothing
- Auto repairs
- Gasoline or mileage
- Purchase or repair of bicycles or other individually owned vehicles
- Transportation to anything other than tenancy or nutrition services
- Transportation for members who are not approved for Flexible Services
- Goods and services for individuals who are not approved for Flexible Services

- Training Contractor or designees on the direct delivery of Flexible Services
- Research grants and expenditures not related to monitoring and evaluation
- Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting
- Services provided to individuals who are not lawfully present in the United States or are undocumented
- Expenditures that supplant services and activities funded by other state and federal governmental entities
- School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state of the local education agency
- Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRS item or service under this demonstration

APPENDIX N
Network Availability Standards

In accordance with Section 2.10 of the Contract, the Contractor shall ensure its Provider Network meets the following availability standards in addition to all other requirements set forth in the Contract. Specifically, at least 90% of Enrollees in each of the Contractor's Service Areas must have access to Providers in accordance with the time and distance standards below. As set forth in Section 2.10, in determining compliance with the time and distance standards below, the Contractor shall take into account only Providers with open panels and shall consider both walking and public transportation.

A. Physical Health Services

For each Provider type, for each Service Area, the Contractor shall have at least the specified number of Providers within at least the specified time or the specified distance of Enrollees' residences. If no time or distance is indicated, the Contractor shall have at least one Provider located anywhere in the Commonwealth.

Primary Care, OB/GYN, Pharmacy, and Certain Medical Facilities

Provider Type	**Minimum Number of Providers**	**Time (minutes)**	**Distance (miles)**
Adult PCP (all Service Areas except Oak Bluffs and Nantucket)	2	30	15
Adult PCP (Oak Bluffs and Nantucket Service Areas only)	2	40	40
Pediatric PCP (all Service Areas except Oak Bluffs and Nantucket)	2	30	15
Pediatric PCP (Oak Bluffs and Nantucket Service Areas only)	2	40	40
Hospital (Acute Inpatient Services)	1	40	20
Urgent Care	1	30	15
Rehabilitation Hospital	1	60	30
OB/GYN	2	30	15
Pharmacy	1	15	30

For the Hospital (Acute Inpatient Services) requirement above, for Oaks Bluff and Nantucket Service Areas Only, the Contractor may meet this requirement by including in its Provider Network any hospitals located in these Service Areas that provide acute inpatient services or the closest hospital located outside these Service Areas that provide acute inpatient services.

Other Physical Health Specialty Providers

Provider Type	Minimum Number of Providers	Time (min)	Distance (miles)
Allergy	1	-	-
Anesthesiology	1	20	40
Audiology	1	20	40
Cardiology	1	20	40
Dermatology	1	20	40
Emergency Medicine	1	20	40
Endocrinology	1	20	40
Gastroenterology	1	20	40
General Surgery	1	20	40
Hematology	1	20	40
Infectious Disease	1	20	40
Medical Oncology	1	20	40
Nephrology	1	20	40
Neurology	1	20	40
Ophthalmology	1	20	40
Oral Surgery	1	-	-
Orthopedic Surgery	1	20	40
Otolaryngology	1	20	40
Physiatry	1	20	40
Plastic Surgery	1	-	-
Podiatry	1	20	40
Psychiatry	1	20	40
Pulmonology	1	20	40
Rheumatology	1	20	40
Urology	1	20	40
Vascular Surgery	1	-	-

For Oaks Bluff and Nantucket Service Areas only, the Contractor shall have at least one Provider in the above specialties within 40 miles or 40 minutes from Enrollees' residences.

B. Behavioral Health Services (as set forth in Appendix C, Exhibit 3)

For each Provider type, for each Service Area, the Contractor shall have at least the specified number of Providers within at least the specified time or the specified distance of Enrollees' residences. If no time or distance is indicated, the Contractor shall have at least one Provider located anywhere in the Commonwealth.

Behavioral Health Providers

Provider Type	**Minimum Number of Providers**	**Time (min)**	**Distance (miles)**
Psychiatric inpatient adult	2	60	60
Psychiatric inpatient adolescent	2	60	60
Psychiatric inpatient child	2	60	60
Managed inpatient level 4	2	60	60
Monitored inpatient level 3.7	2	30	30
Community Crisis Stabilization level 3.5	2	30	30
Community-Based Acute Treatment for Children and Adolescents (CBAT) - Intensive Community-Based Acute Treatment for Children and Adolescents (ICBAT) - Transitional Care Unit (TCU)	2	30	30
Partial Hospitalization (PHP)	2	30	30
Intensive Outpatient Program (IOP)	2	30	30
Residential Rehabilitation Services level 3.1	2	30	30
Intensive Care Coordination (ICC)	2	30	30
Applied Behavioral Analysis (ABA)	2	30	30
In-Home Behavioral Services	2	30	30
In-Home Therapy	2	30	30
Therapeutic Mentoring Services	2	30	30
Community Crisis Stabilization level	2	30	30
Structured Outpatient Addiction Program (SOAP)	2	30	30
BH outpatient (including psychology and psych APN)	2	30	30
Community Support Program (CSP)	2	30	30
Recovery Support Navigators	2	30	30
Recovery Coaching	2	30	30
Opioid Treatment Program (OTP)	2	30	30

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90791*	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 208.27
MH and SA OP Services	90791*	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 167.15
MH and SA OP Services	90791*	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 143.48
MH and SA OP Services	90791*	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 144.66
MH and SA OP Services	90791*	HO - Master's Level	Psychiatric Diagnostic Evaluation	$ 130.48
MH and SA OP Services	90791*	U3 - Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 81.83
MH and SA OP Services	90791*	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 72.20
MH and SA OP Services	90791	HA - CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 223.27
MH and SA OP Services	90791	HA - CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 182.15
MH and SA OP Services	90791	HA - CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 158.48
MH and SA OP Services	90791	HA - CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 159.66
MH and SA OP Services	90791	HA - CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 145.48
MH and SA OP Services	90791	HA - CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 96.83
MH and SA OP Services	90791	HA - CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 87.20
MH and SA OP Services	90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 131.80
MH and SA OP Services	90792	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 114.31
MH and SA OP Services	90792	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 104.57
MH and SA OP Services	90832	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16
MH and SA OP Services	90832	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90832	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$ 35.49
MH and SA OP Services	90832	U4 - Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 31.32
MH and SA OP Services	90833	U6 - Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 63.83
MH and SA OP Services	90833	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 54.25
MH and SA OP Services	90834	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 115.70
MH and SA OP Services	90834	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 101.66
MH and SA OP Services	90834	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 95.89
MH and SA OP Services	90834	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$ 47.98
MH and SA OP Services	90834	U4 - Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 47.26
MH and SA OP Services	90836	U6 - Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90836	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90837	UG - Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 135.04

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90837	AH - Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 127.53
MH and SA OP Services	90837	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$ 68.87
MH and SA OP Services	90837	U4 - Intern (Master's)	Psychotherapy, 60 minutes	$ 60.77
MH and SA OP Services	90838	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 106.08
MH and SA OP Services	90838	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 91.42
MH and SA OP Services	90846	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 141.42
MH and SA OP Services	90846	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (without patient present)	$ 107.62
MH and SA OP Services	90846	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 100.47
MH and SA OP Services	90846	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 97.55
MH and SA OP Services	90846	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 101.43
MH and SA OP Services	90846	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$ 50.23
MH and SA OP Services	90846	U4 - Intern (Master's)	Family Psychotherapy (without patient present)	$ 48.77
MH and SA OP Services	90847	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 141.42
MH and SA OP Services	90847	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 107.62
MH and SA OP Services	90847	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90847	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 50.23
MH and SA OP Services	90847	U4 - Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 48.77
MH and SA OP Services	90849	UG - Doctoral Level (Child Psychiatrist)	Multi-family group psychotherapy	$ 46.29
MH and SA OP Services	90849	U6 - Doctoral Level (MD / DO)	Multi-family group psychotherapy	$ 38.84
MH and SA OP Services	90849	AH - Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	$ 35.86
MH and SA OP Services	90849	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	$ 33.00
MH and SA OP Services	90849	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	$ 27.69
MH and SA OP Services	90849	U3 - Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	$ 17.96
MH and SA OP Services	90849	U4 - Intern (Master's)	Multi-family group psychotherapy	$ 16.50
MH and SA OP Services	90853	UG - Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 46.29
MH and SA OP Services	90853	U6 - Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 38.84
MH and SA OP Services	90853	AH - Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 35.86
MH and SA OP Services	90853	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	U3 - Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$ 17.96
MH and SA OP Services	90853	U4 - Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 16.50

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90882	UG - Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 51.11
MH and SA OP Services	90882	U6 - Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 44.33
MH and SA OP Services	90882	AH - Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.97
MH and SA OP Services	90882	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 38.36
MH and SA OP Services	90882	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.63
MH and SA OP Services	90882	U3 - Intern (PhD, PsyD, EdD) / or MAT	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 12.00
MH and SA OP Services	90882	U4 - Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 11.81
MH and SA OP Services	90887	UG - Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	U6 - Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	AH - Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 59.40
MH and SA OP Services	90887	U3 - Intern (PhD, PsyD, EdD) / or MAT	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.39

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90887	U4 - Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 35.64
MH and SA OP Services	96372	U6 - Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 31.25
MH and SA OP Services	96372	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 23.22
MH and SA OP Services	97810	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 19.84
MH and SA OP Services	97811	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 19.84
MH and SA OP Services	99202	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 75.25
MH and SA OP Services	99202	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 67.91
MH and SA OP Services	99202	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 60.78
MH and SA OP Services	99203	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 108.55
MH and SA OP Services	99203	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 103.65
MH and SA OP Services	99203	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 88.11
MH and SA OP Services	99204	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 164.00
MH and SA OP Services	99204	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 153.89
MH and SA OP Services	99204	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 133.25
MH and SA OP Services	99205	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.69
MH and SA OP Services	99205	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.31
MH and SA OP Services	99205	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 172.81
MH and SA OP Services	99211	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$ 22.06
MH and SA OP Services	99211	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$ 22.06
MH and SA OP Services	99211	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$ 18.75
MH and SA OP Services	99212	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 52.73

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99212	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 52.73
MH and SA OP Services	99212	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$ 44.82
MH and SA OP Services	99213	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 84.11
MH and SA OP Services	99213	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 84.11
MH and SA OP Services	99213	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$ 71.49
MH and SA OP Services	99214	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 143.98
MH and SA OP Services	99214	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 118.51
MH and SA OP Services	99214	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$ 100.73
MH and SA OP Services	99215	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 166.57
MH and SA OP Services	99215	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 166.57
MH and SA OP Services	99215	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$ 141.58
MH and SA OP Services	99231	UG - Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 78.07
MH and SA OP Services	99231	U6 - Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 59.27
MH and SA OP Services	99231	AH - Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 56.89
MH and SA OP Services	99231	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 47.47
MH and SA OP Services	99232	UG - Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 117.11
MH and SA OP Services	99232	U6 - Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 88.19
MH and SA OP Services	99232	AH - Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 84.66
MH and SA OP Services	99232	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 70.63
MH and SA OP Services	99233	UG - Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 156.16
MH and SA OP Services	99233	U6 - Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 117.59
MH and SA OP Services	99233	AH - Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 112.88

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99233	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 94.18
MH and SA OP Services	99251	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 104.74
MH and SA OP Services	99251	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 79.50
MH and SA OP Services	99251	AH - Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 76.32
MH and SA OP Services	99251	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 63.67
MH and SA OP Services	99252	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 157.11
MH and SA OP Services	99252	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 118.32
MH and SA OP Services	99252	AH - Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 113.58
MH and SA OP Services	99252	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 94.77
MH and SA OP Services	99253	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 209.47
MH and SA OP Services	99253	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 157.74
MH and SA OP Services	99253	AH - Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 151.44
MH and SA OP Services	99253	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 126.35
MH and SA OP Services	99254	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 280.95
MH and SA OP Services	99254	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 210.98
MH and SA OP Services	99254	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 169.00
MH and SA OP Services	99255	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 370.12
MH and SA OP Services	99255	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 277.57
MH and SA OP Services	99255	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 222.33

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Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99281	U6 - Doctoral Level (MD / DO)	Emergency Department visit for the evaluation and management of a patient, which requires 3 key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	$ 18.31
MH and SA OP Services	99282	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.15
MH and SA OP Services	99282	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 30.62
MH and SA OP Services	99282	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 29.73
MH and SA OP Services	99283	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 48.65

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99283	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 46.34
MH and SA OP Services	99283	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 44.99
MH and SA OP Services	99284	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 91.44
MH and SA OP Services	99284	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 87.09
MH and SA OP Services	99284	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 84.55

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Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99285	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 135.25
MH and SA OP Services	99285	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 128.81
MH and SA OP Services	99285	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 123.91
MH and SA OP Services	99402	AH - Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling , 30 minutes (Psychological Testing)	$ 40.98
MH and SA OP Services	99402	U3 - Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$ 20.50
MH and SA OP Services	99404	U6 - Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 194.82
MH and SA OP Services	99404	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 168.60

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Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99417	U6 - Doctoral Level (MD / DO)	Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
MH and SA OP Services	99417	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
Diversionary Services	H0037	*N/A*	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	$ 654.13
Diversionary Services	H2012	+	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	101 CMR 307
Diversionary Services	H2012		Behavioral Health Day Treatment, per hour (Enhanced Psychiatric Day Treatment)	101 CMR 307
Diversionary Services	H2015	+	Comprehensive community support services, per 15 minutes (Community Support Program)	$ 13.97
Diversionary Services	H2015		Comprehensive community support services, per 15 minutes (Community Support Program - Cultural Broker)	$ 13.97
Diversionary Services	H2015	HF - Substance Abuse Program	Recovery Support Navigator , per 15-minute units	101 CMR 444
Diversionary Services	H2016	HM - Less than bachelor degree level	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346
Diversionary Services	H2016	HH - Integrated Mental Health/Substance Abuse Program	Comprehensive community support program, per diem for members with justice involvement and behavioral health needs	101 CMR 362
Diversionary Services	H2016	HK - Specialized mental health programs for high-risk populations	Comprehensive community support program, per diem, for members who are 1) experiencing Homelessness and are frequent users of acute health MassHealth services, or 2) are experiencing chronic homelessness	101 CMR 362
Diversionary Services	H2016	HE - Mental Health Program	Comprehensive community support program, per diem, for members who are At Risk of Homelessness and facing Eviction as a result of behavior related to a disability	101 CMR 362
Diversionary Services	H2020	+	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	H2022	HE-Mental Health Program	Intensive Hospital Diversion Services for Children, per diem	$ 175.19
Diversionary Services	S9484	+	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57
MH and SA OP Services	H0004		Behavioral health counseling and therapy, per 15 minutes (individual counseling)	101 CMR 346
MH and SA OP Services	H0005		Alcohol and/or drug services; group counseling by a clinician (per 45 minutes, group counseling, one unit maximum per day)	101 CMR 346
MH and SA OP Services	H0005	HG	Alcohol and/or drug services group counseling by a clinician (per 90-minute unit) (one unit maximum per day)	101 CMR 346

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Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	T1006		Alcohol and/or substance abuse services; family/couple counseling (per 30 minutes, one unit maximum per day)	101 CMR 346
MH and SA OP Services	T1006	HF	Alcohol and/or substance abuse services; family/couple counseling (per 60 minutes, one unit maximum per day)	101 CMR 346
MH and SA OP Services	H0014	+	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
Crisis Intervention Services	S9485	ET - Emergency Services	Crisis intervention mental health services, per diem. (Adult Community Crisis Stabilization per day rate)	101 CMR 305
Crisis Intervention Services	S9485	ET - Emergency Services; HA - Child/Adolescent Program	Crisis intervention mental health services, per diem. (Youth Community Crisis Stabilization Per day rate)	101 CMR 305
Crisis Intervention Services	S9485	HB - Adult Program, non-geriatric	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at hospital emergency department. Inclusive of initial evaluation and all follow-up intervention. Use Place of Service code 23.)	101 CMR 305
Crisis Intervention Services	S9485	HE - Mental Health Program	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	HA-Child/Adolescent Program; HE-Mental Health Program	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	U1-MCI - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions. Use Place of Service 15.)	101 CMR 305
Crisis Intervention Services	S9485	HA - Child/Adolescent Program; U1 - MCI - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions Use Place of Service code 15.)	101 CMR 305
Crisis Intervention Services	S9485	U1 - ESP - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health service, per diem (Emergency Service Program Mobile Non-Emergency Department - Uninsured)	$ 1,024.64
Crisis Intervention Services	S9485	HE-Mental Health Program	Crisis intervention mental health services, per diem (Emergency Service Program Community Based - Uninsured)	$ 695.29
Other Outpatient	90870	+	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95
Other Outpatient	96112	AH - Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96116	AH - Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46
Other Outpatient	96121	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	AH - Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96131	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96132	AH - Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 91.39
Other Outpatient	96133	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96136	AH - Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96137	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	Technician	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$ 22.85
Other Outpatient	96139	Technician	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$ 22.85
Other Outpatient	H0032	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	UG - Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	U6 - Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	H0046	AH - Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U3 - Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	U4 - Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74
Other Outpatient	H2028		Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79
MH and SA OP Services	H0001~~-U1~~	U1 - ESP - Mobile Non-Emergency Department / or MAT	Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	$ 146.93

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

APPENDIX P

Requirements for the Material Subcontracts Between Accountable Care Organizations (ACOs) and Community Partners (CPs)

The Contractor shall maintain material subcontracts (also known as ACO-CP Agreements) with at least one (1) Behavioral Health Community Partner (BH CP) and at least one (1) Long Term Services and Supports Community Partner (LTSS CP) within each of the Contractor's Service Area(s), as specified in **Section 2.6.E** of the Contract and in this **Appendix P**. The Contractor's CP material subcontracts, referred to in this Appendix as "subcontracts," shall be provided to EOHHS upon request and may be reviewed by EOHHS. All requirements set forth herein are applicable to subcontracts with both BH CPs and LTSS CPs unless otherwise specified.

All terms or their abbreviations, when capitalized in this Appendix, are defined as set forth in the Contract or otherwise defined by EOHHS. The Contractor and the CP with which the Contractor enters into a subcontract are referred to collectively herein as the "Parties."

The Parties' subcontracts must comply with applicable laws and regulations, including but not limited to applicable privacy laws and regulations, and with the Contractor's Contract with EOHHS.

The Parties' subcontracts must, at a minimum, contain the information included in this document.

Section 1.1 PAYMENT

A. The Parties' subcontract shall obligate the Contractor to pay the CP as described in **Section 2.6.E.9**.

1. The monthly panel-based payment shall be a rate as further specified by EOHHS.
2. The annual quality performance-based payment shall be based on calculation provided by EOHHS, based on measures provided by EOHHS.
3. This panel-based payment shall be at least the amount specified by EOHHS and account for a homelessness add-on as further specified by EOHHS.

Section 1.2 CP Supports

In addition to the enhanced care coordination requirements described in **Section 2.6.C** of the Contract delegated to the CP by the Contractor, the Parties' subcontract shall require the following:

A. Outreach and Engagement

The Parties' subcontract shall require that the CP develop, implement, maintain, and adhere to a protocol for outreach and engagement of CP Enrollees. Such protocol shall include the requirements in **Section 2.6.C.3** of the Contract, as well as the following requirements:

1. Require the CP to attempt at least one face-to-face visit with each CP Enrollee within the first 3 calendar months of the Enrollee's enrollment in the CP.
2. For each CP Enrollee who agrees to participate in the CP program, require the CP to:

    a. Attest that the CP has performed the outreach and activities described in **Section 2.6.C.3** of the Contract and **Section 1.2** of this **Appendix P** and obtained verbal or written agreement from the CP Enrollee to receive or continue receiving CP supports;

    b. Maintain a copy of the attestation and the CP Enrollee's written agreement, or a record of the CP Enrollee's verbal agreement, if applicable, in the CP Enrollee's record; and

    c. Explain the Protected Information (PI) the CP intends to obtain, use, and share for purposes of providing CP supports;

    d. To the extent deemed necessary by the CP, obtain the CP Enrollee's written authorization to the uses and disclosures of their Protected Information (PI) as necessary for providing CP supports.

3. Require the CP to notify the Contractor if the CP Enrollee declines to participate in the CP program or requests enrollment in a different CP.
4. For BH CPs only, for BH CP Enrollees the BH CP believes are experiencing homelessness or are at risk of homelessness, require the CP use the Homeless Management Information System (HMIS) or other means to:

    a. Confirm whether the Enrollee is currently experiencing or has a history of experiencing homelessness or unstable housing;

    b. Identify which homeless provider agencies and agency staff have worked with the Enrollee, if any. If the Enrollee is not connected with a homeless provider agency, the CP shall immediately work to connect the Enrollee with a homeless provider agency; and

    c. Once the homeless provider agencies and agency staff are identified or connected to the Enrollee, conduct outreach to the homeless provider agencies to gather additional information and invite the homeless provider to participate in the Care Team and care planning for the Enrollee.

B. Comprehensive Assessment

The Parties' subcontract shall require that, for each Enrollee who agrees to participate in the program, the CP shall complete a Comprehensive Assessment, as described in **Section 2.5.B.4** of the Contract. The CP shall utilize a Comprehensive Assessment tool of their choosing that meets the requirements as set forth in **Section 2.5.B.4**. In addition

to the requirements in **Section 2.5.B.4** of the Contract, the Parties' subcontract shall require the following:

1. The CP shall perform Comprehensive Assessments face-to-face unless otherwise specified by EOHHS, and shall take place in a location that meets the Enrollee's needs, including home-based assessments as appropriate.
2. A registered nurse (RN) employed by the CP must review and agree to the Enrollee's medical history, medical needs, medications, and functional status, including needs for assistance with any Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
3. A Clinical Care Manager employed by the CP shall provide final review and approval of the entire Comprehensive Assessment. If the Clinical Care Manager is an RN, review and approval of the Comprehensive Assessment may be completed by one staff member provided all requirements of this Section are met.

C. Health-Related Social Needs Screening and Connection to Community, Social and Flexible Services

The Parties' subcontract shall require that, for each Enrollee who agrees to participate in the program, the CP shall complete a health-related social needs (HRSN) Screening, as described in **Section 2.5.B.3** of the Contract, and shall utilize such tool in connecting Enrollees to community and social supports and Flexible Services. In addition to the requirements in **Section 2.5.B.3** of the Contract, the Parties' subcontract shall require the CP to do the following:

1. Conduct a health-related social needs (HRSN) screening upon enrollment to the CP for those Enrollees who have not had an HRSN screening within the last twelve (12) calendar months that includes all domains and considerations described in **Section 2.5.B.3** of the Contract, and annually thereafter. The HRSN screening may occur as a unique screening, or as part of the Comprehensive Assessment.
2. Utilize the results of any such HRSN screenings when creating a Care Plan and coordinating care.
3. Provide its Heath-Related Social Needs Screening tool to the Contractor and to EOHHS upon request for review and shall make any changes to such tool as directed by EOHHS. EOHHS may require the Contractor to use a specific tool in place of the Contractor's proposed tool.
4. Identify supports to address the Enrollee's identified HRSN(s), including using tools such as the Community Resource Database (CRD) which is provided to the CP by the Contractor, as appropriate;
5. Provide the Enrollee with information about available HRSN-related supports, how to contact such supports, and the accessibility of such supports;
6. Ensure such Enrollees are referred to HRSN-related supports provided by the Contractor, or a Social Services Organization, as applicable. For Enrollees who are referred to a Social Services Organization, the CP shall confirm the Social

Services Organization has the capacity to provide services to the Enrollee and, if not, arrange a referral to another Social Services Organization;

7. Document relevant ICD-10 codes (such as "Z codes" included in categories Z55-65 and Z75 and as further specified by EOHHS);

8. Submit to the Contractor aggregate reports of the identified HRSNs of its enrollees, as well as how those enrollees were referred to appropriate resources to address those identified HRSNs, in a form, format, and frequency specified by EOHHS;

9. Coordinate supports to address HRSNs, including:

    a. Assisting the Enrollee in attending the referral appointment, including activities such as coordinating transportation assistance and following up after missed appointments;

    b. Directly introducing the Enrollee to the service provider, if co-located, during a visit;

    c. Utilizing electronic referral (e.g., electronic referral platform, secure e-mail) to connect the Enrollee with the appropriate provider or Social Service Organization, if the Social Service Organization has electronic referral capabilities, including sharing relevant patient information;

    d. Following up electronically (e.g., electronic referral platform, secure e-mail) with the provider or Social Service Organization, if the Social Service Organization has electronic follow-up capabilities, as needed, to ensure the Enrollee's needs are met.

10. For ACO-enrolled Enrollees, the CP shall provide a Flexible Services Screening and consider referral to Flexible Services, depending on program availability and enrollee eligibility;

    a. For Enrollees identified as needing referrals to Flexible Services (for ACO-Enrolled Enrollees only), Supplemental Nutrition Assistance Program (SNAP), or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the CP shall:

        (i) Provide the Enrollee's contact information and information about the identified HRSN to the entity receiving the referral; and

        (ii) Follow up with the Enrollee to ensure the Enrollee's identified needs are being met.

11. The CP to shall document results of the HRSN screening and include a list of the community and social services resources the Enrollee needs in the Enrollee's Care Plan, as described in **Section 1.2.D** of this Appendix.

D. Development of Care Plan

The Parties' subcontract shall require that the CP develop a Care Plan as described in **Section 2.5.B.5** of the Contract. The CP shall utilize a Care Plan template approved by the Contractor that meets the requirements of **Section 2.5.B.5** of the Contract. In addition to the requirements in **Section 2.5.B.5**, the Parties' subcontract shall require the following:

1. Care Plans shall be reviewed by a registered nurse (RN) employed by the CP. Care Plans shall receive final review and approval by a Clinical Care Manager employed by the CP.
2. The CP shall document within the Enrollee record that the Care Plan was provided to, agreed to, and signed or otherwise approved by the Enrollee.
3. The CP shall complete Care Plans within five (5) calendar months of Enrollee's enrollment with the CP. A Care Plan shall be considered complete when:
    a. The Care Plan has been signed or otherwise approved by the Enrollee; and
    b. The Care Plan has been shared with the Enrollee's PCP or PCP Designee.
4. The CP shall share the completed Care Plan with the Contractor and other parties who need the Care Plan in connection with their treatment of the Enrollee, provision of coverage or benefits to the Enrollee, or related operational activities involving the Enrollee, including members of the Enrollee's Care Team, CBHC staff, if applicable, and other providers who serve the Enrollee, including state agency or other case managers, in accordance with all data privacy and data security provisions applicable.

E. Care Team

The Parties' subcontract shall require that the CP take the lead on forming and coordinating a Care Team for each Enrollee, as described in **Section 2.6.C.4** of the Contract. In addition, the CP shall ensure:

1. That the Care Team meets at least twice within a 12-month period, and
2. That a representative from the care team attends any multidisciplinary team meetings hosted by the Contractor, clinical staff, hospitals and/or other stakeholders to review high-risk Members, if applicable;

F. Care Coordination

The Parties' subcontract shall require that the Enrollee's CP Care Coordinator provide ongoing care coordination support to the Enrollee in coordination with the Enrollee's PCP and other providers as set forth in **Section 2.6.A and Section 2.6.C** of the Contract. In addition, the Parties' subcontract shall:

1. Require CPs to assist Enrollees in the following activities:

a. For Enrollees with behavioral health needs, coordinating with the Enrollee's behavioral health providers to develop the Enrollee's Crisis Prevention Plan to prevent avoidable use of emergency departments, hospitalizations and criminal justice involvement and to provide follow-up if these events occur. The Crisis Prevention Plan shall be documented in the Enrollee's record and shared with the Enrollee's Care Team and other providers.

b. For Enrollees with LTSS needs, assisting with prior authorization for MassHealth State Plan LTSS as applicable. If a service request is significantly modified or denied by MassHealth, the CP shall work with the Enrollee to ensure the Care Plan is adequate to meet the CP Enrollee's needs by working with the CP Enrollee to identify other appropriate supports to meet an unmet need.

c. In addition to implementing the activities necessary to support the Enrollee's Care Plan, as described in **Section 2.5.B.5** of the Contract, ensure the Enrollee has timely and coordinated access to primary, medical specialty, LTSS, and behavioral health care. Such additional activities shall include, but are not limited to:

    (i) Explaining PCP, specialist, and other provider directives to the Enrollee;

    (ii) Providing well-visit, medical, prenatal, outpatient behavioral health, and preventative care reminders;

    (iii) Assisting the Enrollee in scheduling health-related appointments, accessing transportation resources to such appointments, and confirming with the Enrollee that such appointments have been kept;

    (iv) Confirming with the Enrollee that they are adhering to medication recommendations;

    (v) At a minimum, conducting a face-to-face visit at home or in a location agreed upon by the Enrollee, with each Enrollee on a quarterly basis; and

    (vi) Making regular telephone, telehealth, or other appropriate contact with the Enrollee between face-to-face visits.

d. Coordinating with an Enrollee's ACCS provider, if any, as follows:

    (i) Inform the Enrollee's ACCS provider of all of the Enrollee's routine and specialty medical care including identifiable symptoms that may require routine monitoring;

(ii) Coordinate with the Enrollee's ACCS provider to develop the Enrollee's crisis plan to prevent use of emergency departments, hospitalizations and criminal justice involvement and to provide follow-up if these events occur; and

(iii) Coordinate with the Enrollee's ACCS provider regarding activities for improving the Enrollee's health and wellness and to allow ACCS providers to assist and reinforce the Engaged Enrollee's health and wellness goals.

e. For LTSS CPs:

(i) Coordinating with other MassHealth programs that provide Case Management. For Enrollees who (1) participate in a 1915(c) Home and Community-Based Services (HCBS) Waiver, or (2) are receiving targeted case management through DYS case managers, Adult Community Clinical Services, Community Service Agencies (CSAs) who deliver Children's Behavioral Health Initiative services, or DDS service coordinators, or (3) are receiving Community Case Management (CCM), the Enrollee's CP Care Coordinator shall coordinate the provision of LTSS CP Supports with the Enrollee's HCBS Waiver case manager, DDS service coordinator, DYS case manager, CSA and CCM, as applicable, to ensure that LTSS CP supports supplement, but do not duplicate, functions performed by HCBS Waiver case managers, DDS service coordinators, DYS case managers, CSA or CCM.

(ii) Coordinating with the Home Care Program. For Enrollees who are not in a 1915 (c) Home and Community-Based Services (HCBS) Waiver and who participate in the Home Care Program operated by the Executive Office of Elder Affairs (EOEA), the Enrollee's CP Care Coordinator shall coordinate the provision of LTSS CP supports with the Enrollee's Home Care Program case manager to ensure that LTSS CP supports supplement, but do not duplicate, functions performed by the Home Care Program case manager.

2. Obligate the Contractor to provide the CP with information pertaining to ACO Covered Services and non-ACO Covered Services, as described in **Appendix C**, including any such services requiring prior authorization or referrals; and

3. Obligate the Parties to develop, maintain, and implement a mutually agreed upon process for how the Contractor will communicate to the CP any prior authorization decisions (e.g., approval, modification or denial) about, or PCP referrals for, ACO Covered Services and non-ACO covered services.

G. Support for Transitions of Care

In addition to the requirements of **Section 2.6.C.5** of the Contract, the Parties' subcontract shall obligate the CP to:

1. Assist Enrollees who are referred to other levels of care, care management programs, or other providers, in accessing these supports. Such assistance may include, but is not limited to:

    a. Facilitating face-to-face contact between the Enrollee and the provider or program to which the Enrollee has been referred, and directly introducing the Enrollee to such provider or an individual associated with such program (i.e., "warm hand-off"), as appropriate; and

    b. Making best efforts to ensure that the Enrollee attends the referred appointment, if any, including coordinating transportation assistance and following up after missed appointments.

H. Connections to Options Counseling for Enrollees with LTSS Needs

The Parties' subcontract shall require the CP to provide information and support to each Enrollee with LTSS needs, their guardians/caregivers and other family members, as applicable, about assisting the Enrollee to live independently in their community. The Parties subcontract shall require that:

1. Such information includes, but not be limited to:

    a. Long-term services and supports;

    b. Resources available to pay for the services;

    c. The MassOptions program which can provide the Enrollee with options counseling.

2. The CP provide Enrollees support by:

    a. Assisting with referrals and resources as needed;

    b. Assisting in making decisions on supportive services, including but not limited to, finding assistance with personal care, household chores, or transportation;

    c. Assisting, as appropriate, in connecting to a counselor at MassOptions; and

    d. Informing the Enrollee about their options for specific LTSS services and programs for which they may be eligible, the differences among the specific types of LTSS services and programs and the available providers that may meet the Enrollee's identified LTSS needs.

3. In performing this function, the CP shall document that the Enrollee was informed of multiple service options available to meet their needs, as appropriate, and reviewed and provided with access to a list of all MassHealth LTSS providers in their geographic area for each service option, when applicable.

Section 1.3 HEALTH EQUITY

The Parties' subcontract shall require the CP to collaborate with the Contractor on certain metrics and initiatives related to Health Equity, as described in **Section 2.21** of the Contract. Specifically, the Parties' subcontract shall:

A. Require the CP to collect and submit to the Contractor Enrollee-level social risk factor data (including race, ethnicity, language, disability status, age, sexual orientation, gender identity, and health-related social needs) using a screening tool and/or questionnaire provided by the Contractor when requested by the Contractor; and

B. Require the CP to support the Contractor's Health Equity initiatives, including but not limited to development of the Contractor's Health Equity Strategic Plan and Report, when such initiatives would benefit from involvement of the CP.

Section 1.4 REPORTING

The Parties' subcontract shall:

A. Obligate the Contractor to:

1. Report to its CPs monthly on monthly panel-based payments made in a form and format specified by EOHHS;
2. Report to its CPs on quality payments made, on an annual basis, and in a form and format specified by EOHHS;
3. Provide its CPs monthly assignment files as further described by EOHHS in a form and format specified by EOHHS; and
4. Provide its CPs EOHHS renewal and redetermination files.

B. Obligate the CP to:

1. Provide to the Contractor monthly Enrollment and Disenrollment files in a format specified by EOHHS;
2. Provide the Contractor data related to Health Equity as set forth in **Section 1.3.A of this Appendix P**.
3. Provide other reports to the Contractor as identified and agreed upon by both Parties.

Section 1.5 INTEROPERABILITY, RECORD KEEPING, COMMUNICATION AND POINTS OF CONTACT

A. Interoperability and Record Keeping

The Parties subcontract shall include requirements for information and data sharing, including but not limited to record keeping and changes to Enrollee's enrollment or engagement in the CP as set forth in **Section 2.6.E.10**, and shall at a minimum:

1. Obligate the Parties to enter into and maintain an agreement governing the CP's use, disclosure, maintenance, creation or receipt of protected health information

(PHI) and other personal or confidential information in connection with the subcontract that satisfies the requirements under the Privacy and Security Rules, includes any terms and conditions required under a data use agreement between the Contractor and EOHHS and otherwise complies with any other privacy and security laws, regulations and legal obligations to which the Contractor is subject;

2. Include such agreement as an appendix to the subcontract;

3. Specify that no Party to the subcontract may obligate the other Party to use a specific Information Technology, Electronic Health Record system, or Care Management system;

4. Obligate both Parties to develop, maintain, and implement a mutually agreed processes for the exchange of Enrollee data between the Parties;

    a. Specify the elements included in such data exchange, which shall include at a minimum: Enrollee name; date of birth; MassHealth ID number; MassHealth Assignment Plan; Enrollee address and phone number; Enrollee Primary Language (if available); and PCP name, address, and phone number;

    b. Specify the frequency of such data exchange, which shall not be less than monthly;

    c. Specify the file type of such data exchange (e.g., Excel file or other mutually agreed upon file type);

    d. Specify the secure transmission method (e.g., secure email or the Mass HIway).

5. Obligate both Parties to develop and implement requirements around record keeping, including that:

    a. The CP shall maintain an information system for collecting, recording, storing and maintaining all data required under the Contract.

    b. The CP shall maintain a secure Electronic Health Record for each Enrollee that includes, but is not limited to, a record of:

        (i) All applicable Comprehensive Assessment and Care Plan elements, as described in **Sections 1.2.B** and **1.2.C** of this **Appendix P**;

        (ii) A timely update of communications with the Enrollee and any individual who has direct supportive contact with the Enrollee (e.g., family members, friends, service providers, specialists, guardians, and housemates), including, at a minimum:

            (a) Date of contact;

(b) Mode of communication or contact;

(c) Identification of the individual, if applicable;

(d) The results of the contact; and

(e) The initials or electronic signature of the Care Coordinator or other staff person making the entry.

(iii) Enrollee demographic information.

c. The CP shall ensure that all Enrollee Electronic Health Records are current and maintained in accordance with this Contract and any standards as may be established from time to time by EOHHS; and

d. The CP shall provide the Contractor with a copy of the Enrollees' Electronic Health Records within thirty (30) calendar days of a request.

6. Obligate both Parties to develop, maintain, and implement a mutually agreed upon process for changes to Enrollee enrollment or engagement with the CP, including:

a. Specify the Contractor's process for processing requests from Enrollees to enroll in a different CP or disengage from the CP;

b. Specify the process by which the Contractor, in consultation with the CP, will determine if CP supports are no longer necessary for an Enrollee; and

c. Specify the form, format and frequency for communications between the Parties regarding changes to Enrollee enrollment or engagement and the processes for transitioning such Enrollee's care coordination.

7. The Parties' subcontract shall require that the CP maintain a record of Qualifying Activities performed for each Enrollee as further specified by EOHHS.

B. Communication and Points of Contact

The Parties' subcontract shall include requirements for communication and identification of points of contact, and shall at a minimum:

1. Obligate both Parties to establish key contact(s) who will be responsible for regular communication between the Parties about matters such as, but not limited to, data exchange, and care coordination, as described in **Section 2.6.E.12** of the Contract.

2. Obligate both Parties to provide the other Party information about key contact(s), including at a minimum the key contact's name, title, organizational affiliation, and contact information;

3. Obligate both Parties to provide each other with timely notification if such key contact(s) change; and

4. Obligate both Parties to develop, implement, and maintain a mutually agreed upon process for reporting of gross misconduct or critical incident involving an Enrollee to each other, as described in this **Appendix P**. The Parties' subcontract shall require the CP to develop, implement, maintain, and adhere to procedures to track, review, and report critical incidents. The procedures shall:

    a. Be jointly developed

    b. Require the CP to document critical incidents including:

        (i) Fatalities and near fatalities;

        (ii) Serious injuries;

        (iii) Medication-related events resulting in significant harm;

        (iv) Serious employee misconduct;

        (v) Serious threats of harm to Enrollees, CP employees or others;

        (vi) Require the CP to report critical incidents to the Contractor and the appropriate agencies and authorities;

    c. Require the CP to designate key personnel to track, report and monitor critical incidents;

    d. Require the CP to review critical incidents by committee which includes a Medical Director and Clinical Care Manager, at least quarterly; and

    e. Require the CP to take proactive steps to modify processes to avoid future incidents.

Section 1.6 PERFORMANCE MANAGEMENT AND CONFLICT RESOLUTION

The Parties' subcontract shall include requirements for performance management and compliance as set forth in **Section 2.6.E.3** of the Contract, as well as for conflict resolution. The Parties' subcontract shall, at a minimum:

A. Include a mutually agreed upon process for continued management of the subcontract, including:

1. Specifying the frequency and format of regular meetings between the Parties for the purposes of discussing the Parties' compliance under the Parties' subcontract; and

2. Specifying the intended topics of discussion during such meetings, which may include topics such as, but not limited to, Enrollee outreach, engagement, cost,

utilization, quality and performance measures, communication between the Parties, and Enrollee grievances.

3. Include a mutually agreed upon process for conflict resolution to address and resolve concerns or disagreements between the Parties which may arise, including but not limited to clinical, operational and financial disputes.

4. Outline a mutually agreed upon process for CP performance management that may include but is not limited to the following set of escalating steps: development and implementation of a performance improvement plan, development and implementation of a corrective action plan, non-compliance letter, and contract termination. Such process for performance management shall:

    a. Specify the areas in which the Contractor shall monitor CP performance and relevant data sources for such monitoring

    b. Specify the areas in which the Contractor shall engage in performance management of the CP, which must include: fidelity to CP Supports as outlined in the Parties' subcontract, critical incident reporting, grievances, record keeping, and other responsibilities or performance indicators outlined in the Parties' subcontract.

5. Obligate both Parties to develop processes relating to the types, frequency, and timeliness of bidirectional reports on performance, outcomes, and other metrics;

6. Obligate both Parties to establish a cadence for the Parties' leadership to engage on the output of such reports, in order to identify and jointly agree upon areas to improve Enrollee care and performance on financial, quality, and utilization goals, including specifications on who will be responsible for engaging with such reports.

Section 1.7 ENROLLEE PROTECTIONS

A. Grievances

The Parties' subcontract shall require that the CP develop, implement, maintain, and adhere to written policies and procedures for the receipt and timely resolution of Grievances from Enrollees. Such policies and procedures shall require the CPs to:

1. At least annually, the CP shall notify the Contractor of any grievances the CP received and the resolution of the grievance.

2. At least annually, the Contractor shall notify EOHHS of any grievances the CP or Contractor has received regarding the CP program and the resolution of the grievance.

B. Information and Accessibility Requirements

The Parties' subcontract shall require that:

1. With respect to any written information it provides to Enrollees, the CP make such information easily understood as follows:

a. Make such information available in prevalent non-English languages specified by EOHHS;

b. Make oral interpretation services available for all non-English languages, including American Sign Language, available free of charge to Enrollees and notify Enrollees of this service and how to access it; and

c. Make such information available in alternative formats and in an appropriate manner that takes into consideration the special needs of Enrollees, such as visual impairment and limited reading proficiency, and notify Enrollees of such alternative formats and how to access those formats.

2. The CP ensures that Enrollee visits with Care Coordinators are conducted in a manner to accommodate an Enrollee's disability and language needs, including the use of safe and accessible meeting locations, language assistance (e.g., access to qualified interpreters), and auxiliary aids and services (e.g., documents that are accessible to individuals who are blind or have low vision).

C. Enrollee Rights

The Parties' subcontract shall require that the CP have written policies ensuring Enrollees are guaranteed the rights described in **Section 5.1.L** of the Contract, and ensure that its employees, Affiliated Partners, and subcontractors observe and protect these rights. The CP shall be required to inform Enrollees of these rights upon Enrollees' agreement to participate in the CP program.

Section 1.8 OMBUDSMAN

The Parties' subcontract shall require that the CP supports Enrollee access to, and work with, the EOHHS Ombudsman to address Enrollee requests for information, issues, or concerns related to the CP or ACO program, as described in **Section 2.13.A.8** of the Contract.

Section 1.9 TERMINATION

A. The Contractor's subcontract shall, at minimum:

1. Obligate both Parties, prior to termination of the subcontract by either Party, to:

a. Follow all conflict resolution processes, as appropriate, described in this **Appendix P**;

(i) Provided however that if both Parties agree to terminate the subcontract for reasons other than for-cause, the Parties may terminate the subcontract without following all conflict resolution processes described in this Appendix;

b. If EOHHS terminates the relevant contract with the Contractor or CP, termination of the subcontract may be made without following all conflict resolution processes described in this **Appendix P**; and

c. If EOHHS notifies a Party to the subcontract, indicating that the other Party has materially breached its contract with EOHHS, in the sole determination of EOHHS, the first Party may terminate the subcontract without following all conflict resolution processes described in this **Appendix P**;

2. Specify that in the event of termination of the subcontract, the obligations of the Parties under the subcontract, with regard to each shared Enrollee at the time of such termination, will continue until the CP has provided a warm hand-off of the Enrollee to the Contractor, a new ACO or MCO, or a new CP, if applicable, and the transition of Enrollee data in accordance with the Parties' data policies, provided, however, that the Parties shall exercise best efforts to complete all transition activities within one month from the date of termination, expiration, or non-renewal of the subcontract.

Appendix Q

EOHHS Accountable Care Organization Quality and Health Equity Appendix

This Appendix details how EOHHS will determine the Contractor's Quality and Health Equity Performance as described in the Contract. EOHHS reserves the right to modify the methodology set forth herein prior to execution of the Contract. EOHHS may modify the methodology set forth herein after the execution of the Contract by written amendment. The following information is included. For the purposes of this document, "Performance Year" or "PY" shall mean "Contract Year" as defined in Section 1 of the Contract, unless otherwise specified by EOHHS.

1 Overview of Quality Performance and Scoring and Health Equity Performance and Scoring

The Contractor shall receive, for each Performance Year, an ACO Quality Score that shall determine the Quality Incentive payment amount available to the Contractor as prescribed in **Sections 2.14** and **4.6.B** of the Contract. The Contractor shall also receive, for each Performance Year, an ACO Health Equity Score that shall determine the Health Equity incentive payment amount available to the Contractor as prescribed in **Sections 2.21** and **4.6.C** of the Contract. The Contractor shall also receive, for each Performance Year, a CP Quality Score (calculated by EOHHS) for each Community Partner subcontractor as described in **Section 2.6.E** of the Contract. The CP Quality Score shall be used in the determination of incentive payments made by the Contractor to each of its subcontracted CPs.

This Section of the Appendix describes the individual measures, and general methodology EOHHS will use to calculate the Contractor's scores (i.e., ACO Quality Score, ACO Health Equity Score, and CP Quality Score), as further specified by EOHHS.

2 Scoring Methodology for ACO Quality Score

The Contractor's Quality Score is based on the Contractor's performance across a set of benchmarks and improvement targets for individual measures that are grouped into three domains. EOHHS will weight and sum the Contractor's performance across domains to calculate one overall ACO Quality Score per performance year. For any measure where the Contractor does not meet minimum denominator requirements, as determined by EOHHS, then the measure's weight will be equally distributed to other measures within the same domain.

For ACOs serving primarily pediatric members (e.g., ≥ 75% of the ACO's Enrollees are ages 0-17 years), EOHHS shall replace adult focused measures (i.e., measures applicable to 18+ populations only) with measure(s) applicable to pediatric populations only ("pediatric replacement measures") as further specified by EOHHS. Quality Performance on these pediatric replacement measures will be scored as described above.

2.a List of Quality Measures for ACO Quality Score

Quality Measures include claims-based measures, clinical quality measures, and member experience surveys across the following three domains:

- Preventive and Pediatric Care
- Care Coordination / Care for Chronic & Acute Conditions
- Member Experience

See Exhibit 2 for the list of Quality Measures.

EXHIBIT 2 – ACO Quality Measures

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.
Preventive and Pediatric Care	Developmental Screening in the First 3 Years of Life	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Claims/ Hybrid	OHSU	1448
	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	NCQA	1407
	Childhood Immunization Status	Percentage of members 2 years of age who received all recommended vaccines by their second birthday	Hybrid	NCQA	0038
	Prenatal and Postpartum Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment Percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery	Hybrid	NCQA	N/A
	Topical Fluoride for Children at Elevated Caries Risk	Percentage of children aged 1–21 years who are at “elevated” risk (i.e. “moderate” or “high”) who received at least 2 topical fluoride applications within the reporting year	Claims	ADA DQA	2528
	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Hybrid	CMS	0418

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0
Care Coordination/ Care for Acute and Chronic Conditions	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 days	Claims	NCQA	3489	Yes
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who has a follow up visit for AOD	Claims	NCQA	3488	No
	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576	Yes
	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	NCQA	0018	Yes
	Comprehensive Diabetes Care: HBA1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059	Yes
	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800	Yes

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004	Yes
Member Experience	Overall Care Delivery	Composites related to overall experience (e.g., Willingness to Recommend, Communications)	Survey	AHRQ	N/A	Yes
	Person-Centered Coordination/Integration of Care	Composites related to coordination of care (e.g., referrals, services etc.) and knowledge of the patient	Survey	AHRQ	N/A	Yes

Exhibit 2.A – ACO Quality Measures: Pediatric Replacement Measures

Domain	Measure Name	Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0
Care Coordination/Care for Acute and Chronic Conditions	Metabolic Monitoring for Children and Adolescents on Antipsychotics *Replacing: Controlling High Blood Pressure* and *Comprehensive Diabetes Care: HBA1c Poor Control*	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Claims	NCQA	2800	Yes

2.b Measure Level Scoring Methodology (Achievement and Improvement Points)

1. Achievement Points

The Contractor may receive up to a maximum of ten (10) achievement points for each Quality Measure, as follows:

1. EOHHS will establish an "attainment threshold" and a "goal benchmark" for each Quality Measure
    a. "Attainment threshold" sets the minimum level of performance at which the contractor can earn achievement points
    b. "Goal benchmark" is a high performance standard above which the Contractor earns the maximum number of achievement points (i.e., 10 points)
2. EOHHS will calculate the Contractor's performance score on the Quality Measure based on the measure specifications
3. EOHHS will award the Contractor between zero (0) and ten (10) achievement points as follows:
    a. If the Contractor's performance score is less than the attainment threshold: 0 achievement points
    b. If the Contractor's performance score is greater than or equal to the goal benchmark: 10 achievement points
    c. If the performance score is between the attainment threshold and goal benchmark: achievement points earned are determined by the formula:
        i. 10*((Performance Score – Attainment Threshold) / (Goal Benchmark – Attainment Threshold))

EXHIBIT 3 – Example Calculation of Achievement Points for Measure A

Measure A attainment threshold = 45% (e.g., corresponding to 25th percentile of HEDIS benchmarks) **Measure A goal benchmark** = 80% (e.g., corresponding to 90th percentile of HEDIS benchmarks)
Scenario 1:
• Measure A performance score = 25%
• Achievement points earned = 0 points
Scenario 2:
• Measure A performance score = 90%
• Achievement points earned = 10 points
Scenario 3:
• Measure A performance score = 60%
• Achievement points earned = 10*((60% - 45%) / (80% - 45%)) = 4.29 points

2. Improvement Points

In addition to receiving achievement points based on performance (on a 0 to 10 scale), the Contractor may earn improvement points for reaching established improvement targets for each Quality Measure. Improvement points will be calculated as follows:

1. EOHHS will calculate the Contractor's performance score on each Quality Measure based on the measure specifications. Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

2. Beginning PY2, EOHHS will compare the Contractor's performance score on each Quality Measure to the Contractor's performance score on that same Quality Measure from the highest scoring previous Performance Year.

3. EOHHS will calculate an Improvement Target for each Quality Measure using the following formula (unless otherwise communicated by EOHHS). The Improvement Target is based on at least a 20% improvement each year in the gap between Goal Benchmark and the Attainment Threshold of each ACO measure.

    a. Improvement Target formula = [(Goal Benchmark –Attainment Threshold) /5]

For example, for Measure A, if the Attainment Threshold is 50% and the Goal Benchmark is 60%, the Improvement Target is 2% [(60 – 50)/5)]

    b. For the purposes of calculating the Improvement Target, the result is rounded to the nearest tenth (i.e., one decimal point).

For example, for Measure B, if the Attainment Threshold is 80% and the Goal Benchmark is 90.2%, the Improvement Target is calculated to 2.04% [(90.2 – 80)/5)] which rounds to 2.0%.

    c. The Contractor may earn up to five (5) improvement points for increases in measure score which meet or exceed the improvement target.

For example, for Measure B, the Improvement Target is 2.0%. If Contractor performance in PY4 is 54.0% and if Contractor performance in PY5 is 60.0%, the Contractor improvement from PY4 to PY5 is 6.0% [(60.0-54.0)] and the Contractor is awarded 5 improvement points. No points above 5 are awarded for increases in excess of the improvement target.

    d. For the purposes of calculating the difference in Contractor quality performance over a previous year, the results are rounded to the nearest tenth (i.e., one decimal point). Rounding takes place after the calculation.

For example, for Measure B, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 60.17%, the Contractor improvement from PY4 to PY5 is 5.63% [(60.17-54.54)], and the Contractor improvement will be rounded to the nearest tenth (i.e., one decimal point) to 5.6%.

    e. The Improvement Target is based on the ***higher*** of the original baseline or any year's performance prior to the current PY. This is intended to avoid rewarding regression in performance.

For example, for Measure B, assume Contractor performance in PY1 is 90.0% and the Improvement Target is 2.0%. If in PY4 the performance for the Contractor decreases to 89.0%, in PY5 the Contractor would need to reach 92.0% to reach the Improvement Target.

    f. There are several special circumstances:

        i. *At or Above Goal:* If the Contractor has prior PY performance scores equal to or greater than the Goal Benchmark then the Contractor may

still earn up to five (5) improvement points in each PY if improvement from the highest prior PY is greater than or equal to the Improvement Target.

ii. *At or Below Attainment:* If the Contractor has prior PY performance scores less than the Attainment Threshold then the Contractor may still earn up to five (5) improvement points each PY if improvement from the highest prior PY is greater than or equal to the Improvement Target, and performance in the current PY does not equal or exceed the Attainment Threshold. Additionally, if the Contractor has prior PY performance scores less than the Attainment Threshold and current PY performance scores are equal to or above the Attainment Threshold then the Contractor may still earn up to five (5) improvement points if the improvement is greater than or equal to the Improvement Target.

EXHIBIT 4 – Example Calculation of Improvement Points for Measure B

Measure B Attainment = 48.9% | Goal = 59.4% | Improvement Target = 2.1%

	PY4 Score	PY5 Score	Improvement	Improvement Target Met	Improvement Points Earned
Scenario 1:	50.0%	52.1%	2.1%	Yes	5
Scenario 2:	50.0%	56.7%	6.7%	Yes	5
Scenario 3:	59.5%	63.0%	3.5%	Yes; above Goal Benchmark	5
Scenario 4	45.0%	48.0%	3.0%	Yes; below Attainment Threshold	5
Scenario 5:	46.0%	49.0%	3.0 %	Yes; crossing Attainment	5
Scenario 6:	45.0%	46.0%	1.0%	No	0

2.c Domain Level Scoring Methodology

EOHHS will sum the Contractor's achievement and improvement points for all Quality Measures within each Quality Domain. Improvement points earned in one Quality Domain may only be summed with achievement points from the same Quality Domain. The total number of points earned by the Contractor in each domain cannot exceed the maximum number of achievement points available in the domain. The maximum number of achievement points in the domain is calculated by multiplying the number of Pay-for-Performance (P4P) measures in the domain, in the given PY, by the number of available achievement points per measure.

For example, if in PY4, there are ten (10) clinical quality measures in Domain X in Pay-for-Performance, and each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 100. Assume that in PY5 there are now twelve (12) clinical quality measures in Domain X in Pay-for-Performance, and that each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 120.

Cumulative Example:
Total number of measures in domain: 2
Maximum number of achievement points in the domain = 20
Measure Attainment = 48.9% | Goal = 59.4%
Improvement Target = [(Goal Benchmark –Attainment Level) /5] = [59.4-48.9]/5 = 2.1

For example, for Measure A, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 58.17% the Contractor will earn 8.8 Achievement Points [10 * (58.17 – 48.9)/(59.4 – 48.9)]. The Contractor has improved from PY4 to PY5 by 3.63% [(58.17 - 54.54)] which will be rounded to the nearest tenth (e.g., one decimal point) to 3.6% which exceeds the Improvement Target of 2.1%. Thus, the Contractor will earn five (5) improvement points. No points above 5 are awarded for increases in excess of the improvement target.

In this scenario the Contractor would earn 13.8 points.

If there is only one (1) additional measure in the Domain and the Contractor earned 9 total points for this measure; the total score for the Contractor would be 20.0 (out of 20) given that domain scores are capped at the maximum number of achievement points (20) in the domain.

Once the total number of points has been calculated, EOHHS will divide the resulting sum by the maximum number of achievement points that the Contractor is eligible for in the domain to produce the Contractor's Domain Score. Domain Scores are a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). EOHHS will score the Contractor on each P4P Quality Measure unless the Contractor does not meet eligibility requirements for a specific measure (e.g., it does not meet the minimum denominator requirement). In cases like this, the measure is not factored into the denominator. Reporting measures do not factor into the Domain Score. Additionally, improvement points do not count towards the denominator; they are therefore "bonus" points. Domain Scores are each capped at a maximum value of 100%.

EXHIBIT 5 – Example Calculation of an Unweighted Domain Score

Example Calculations of Unweighted Domain Score		
Example 1	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 1.5
		Improvement Points: 0
	Measure B:	Achievement points: 0
		Improvement Points: 5
	Total achievement points: 1.5 + 0 = 1.5 points	
	Total improvement points: 0 + 5 = 5 points	
	Sum of achievement and improvement points: 1.5 + 5 = 6.5 points	
	Unweighted domain score = 6.5/20 * 100 = 32.5%	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 8

		Improvement Points: 5
	Measure B:	Achievement points: 9.3
		Improvement Points: 0
	Total achievement points: 8 + 9.3 = 17.3	
	Total improvement points: 5 points	
	Sum of achievement and improvement points: 17.3 + 5 = 22.3 points	
	However, total number of points cannot exceed maximum number of achievement points (20)	
	Therefore, total domain points = 20	
	Unweighted domain score = 20/20 * 100 = 100%	

3 Scoring Methodology for ACO Health Equity Score

1. **Overview of Targeted Domains for Improvement.** EOHHS will calculate the Contractor's Health Equity Score for purposes of the Health Equity Incentive as set forth in **Section 4.6.C** based on the Contractor meeting data collection requirements, reporting expectations, and achieving quality and equity improvement standards across the following three domains:
    a. **Demographic Data and Health-Related Social Needs Data**: EOHHS shall assess the Contractor on the completeness of Enrollee-reported demographic and Health-related Social Needs data submitted in accordance with EOHHS-specified data requirements. Demographic and Health-related Social Needs data shall include at least the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and Health-related Social Needs. EOHHS shall assess data completeness separately for each data element.
    b. **Equitable Access and Quality**: EOHHS shall assess the Contractor on performance and demonstrated improvements on EOHHS-specified access and quality metrics, including associated reductions in disparities.
    c. **Capacity and Collaboration**: EOHHS shall assess the Contractor on improvements in EOHHS-specified metrics, such as provider and workforce capacity and collaboration between health system partners to improve quality and reduce health care disparities.

2. **Demographic Data and Health-Related Social Needs Data:**
    a. The Contractor will be incentivized through annual milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data by end of PY3.
    b. The Contractor will be incentivized through annual milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including primary language, disability status, sexual orientation and gender identity) by the end of PY5.
    c. The Contractor will be incentivized to meaningfully improve rates of Health-related Social Needs screenings from a baseline period specified by EOHHS by the end of PY5. To meet

this goal, the Contractor shall conduct screenings of Enrollees and establish the capacity to track and report on screenings and referrals.

3. **Equitable Quality and Access Domain Goals:**
    a. The Contractor will be incentivized for performance on metrics such as those related to access to care (including for individuals with limited English proficiency or disability), preventive, perinatal, and pediatric care, care for chronic diseases, behavioral health, care coordination, and patient experience.
    b. Metric performance expectations shall be specified further by EOHHS and shall include, at a minimum:

        i. For up to the first three Performance Years:
            1. Reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, primary language, disability, sexual orientation, and gender identity); Health-related Social Needs; and defined by other individual- or community-level markers or indices of social risk;
            2. Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics (as further detailed in Appendix B).
        ii. For at least the last two Performance Years, the metric performances above, as well as improving quality or closing disparities as measured through performance on a subset of access and quality metrics (as further identified by EOHHS)

4. **Capacity and Collaboration Domain Goals:**
    a. Domain level requirements to be further specified by EOHHS.

4 Scoring Methodology for Community Partners Quality Score

EOHHS shall calculate a Community Partner Quality Score for each of the Contractor's subcontracted CPs. Community Partner Quality Scores are based on the performance of each subcontracted CP's MassHealth enrollment, as determined by EOHHS, across a set of benchmarks or improvement targets for individual measures within the BH CP or LTSS CP measure slate as applicable as set forth in Exhibits 5 and 6 below. EOHHS will weight each CP's CP Quality Score by the volume of that CP's enrollment within the ACO relative to the volume of all other CP subcontractors within the same ACO. As further specified by EOHHS, EOHHS shall use the weighted CP Quality Score to determine the Contractor's payment to each CP based on the CP's quality performance. In addition to the above methodology, EOHHS may establish additional quality incentives designed to reward the Contractor's higher performing subcontracted CPs.

4.a Quality Measures for CP Quality Score

Exhibit 6 – BH CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0
Follow-up with BH CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP within x business days of discharge	Claims	EOHHS	NA	Yes
Follow-up with BH CP after ED visit (x days)	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within x days of the ED visit	Claims	EOHHS	NA	Yes
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA	Yes
Initiation/Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004	Yes
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576	Yes
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	Claims	NCQA	1932	Yes
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on	Claims	NCQA	0105	Yes

Measure Name	Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0
	antidepressant medication treatment				
Treatment Plan Completion	TBD	Claims	EOHHS	NA	Yes
Member Experience	TBD	Survey	EOHHS	NA	Yes

Exhibit 7 – LTSS CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0
Follow-up with LTSS CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a LTSS CP within x business days of discharge	Claims	EOHHS	NA	Yes
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA	Yes
Care Plan Completion	TBD	Claims	EOHHS	NA	Yes
Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	Claims	ADA	NA	Yes
Member Experience	TBD	Survey	EOHHS	NA	Yes

5 Methodology for Establishing Performance Benchmarks for Quality Measures

EOHHS will establish the attainment threshold, goal benchmark, improvement target (and/or any other applicable performance indicator) for each Quality Measure applicable to ACO Quality, ACO Health Equity, and CP Quality scoring methodologies. EOHHS anticipates establishing these performance indicators as follows:

- For Quality Measures based on NCQA HEDIS measures, EOHHS anticipates using NCQA Quality Compass percentiles, as well as MassHealth historical ACO and Community Partners' performance

- For non-HEDIS Quality Measures, EOHHS anticipates using MassHealth historical ACO and Community Partners' performance
- For other Quality Measures where EOHHS does not have access to applicable data, EOHHS anticipates using MassHealth benchmarks based on ACO/CP-attributed populations

6 Quality Performance Financial Application

The Contractor's ACO Quality Score and ACO Health Equity Score will be applied to performance incentive payment as described in **Section 4.6.** Community Partner Quality Scores will be applied to incentive payments to CP subcontractors as described in **Section 2.6.E.**

Appendix R

Contractor Information

Contractor Legal Name: Boston Medical Center Health Plan, Inc.

Contractor ACO Partner Name (if applicable): Boston Children's Health Accountable Care Organization, LLC

Contractor ACO Name (if applicable): WellSense Boston Children's ACO

Contractor Principal Offices Address: Schrafft's City Center, 529 Main Street, Suite 500 Charlestown, MA 02129

Contractor Recipient of Written Notices:

Nelie Lawless
Boston Medical Center Health Plan, Inc.
Schrafft's City Center
529 Main Street, Suite 500
Charlestown, MA 02129

Appendix S

Directed Payments Related to Certain ACO Covered Services

Exhibit 1: HCBS Temporary Rate Increases by Service

Exhibit 1A Summary of HCBS Rate Increases

Covered Service	Increase	Rate Increase Effective Date	Rate Increase End Date
Home Health Services	10%	4/1/2023	12/31/2023

The Contractor shall refer to the following MassHealth Provider Manual sections for additional detail on applicable codes for each service:

- https://www.mass.gov/doc/independent-nurse-in-subchapter-6-0/download
- https://www.mass.gov/doc/home-health-agency-hha-subchapter-6/download
- www.mass.gov/doc/continuous-skilled-nursing-agency-csn-subchapter-6-0/download

Exhibit 2: Summary of Behavioral Health Services Rate Increases by Service

Covered Service*	Increase	Rate Increase Effective Date	Rate Increase End Date
Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services for Substance Use Disorders (including Individualized Treatment Services)	10%	4/1/2023	6/30/2023
Community-Based Acute Treatment for Children and Adolescents (CBAT)	10%	4/1/2023	6/30/2023
Intensive Outpatient Program (IOP)	10%	4/1/2023	6/30/2023
Partial Hospitalization (PHP)	10%	4/1/2023	6/30/2023
Program of Assertive Community Treatment (PACT)	10%	4/1/2023	6/30/2023
Psych Day Treatment	10%	4/1/2023	6/30/2023
Residential Rehabilitation Services for Substance Use Disorders, including Transitional Age Youth and Young Adult Residential, Youth Residential, and Pregnancy Enhanced Residential	10%	4/1/2023	6/30/2023
Structured Outpatient Addiction Program (SOAP)	10%	4/1/2023	6/30/2023
Transitional Care Unit (TCU)	10%	4/1/2023	6/30/2023

*Such covered services include the services set forth in Appendix O except as set forth below as well as the following services:

CBAT – Community Based Acute Treatment (Rev Code 1001), TCU – Transitional Care Unit (Rev codes 0100, 0114, 0124, 0134, 0144, 0154), IOP – Intensive Outpatient Psychiatric (Rev Code 0905, 0906 CPT 90834), , PACT – Program of Assertive Community Treatment (H0040, ATS H0011 or

rev code 1002 for MBHP), RSS (H0019), CSS (H0010 or rev code 907 for MBHP), CSP-SIF – Community Support Program - Social Innovation Financing for Chronic Homelessness Program (H2016 SE), CSP-CHI – Community Support Program for Chronically Homeless Individuals (H2016 HK)

Such covered services do not include the following services set forth in Appendix O:

Certain Consult codes and E&M codes (99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285), Specialing (T1004), ASAP (H2028), SUD medication (J0571, J0572, J0573, J2315, J3490)