COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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

CONTRACTOR LEGAL NAME: Fallon Community Health Plan, Inc. **(and d/b/a):**		**COMMONWEALTH DEPARTMENT NAME: Executive Office of Health and Human Services** **MMARS Department Code:** EHS	
Legal Address: (W-9, W-4): 10 Chestnut St., Worcester, MA, 01608		**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108	
Contract Manager: Janie Liepins	**Phone:** 508-368-9798	**Billing Address (if different):**	
E-Mail: Janis.liepins@fallonhealth.org	**Fax:**	**Contract Manager:** Alejandro Garcia Davalos	**Phone:** 617-838-3344
Contractor Vendor Code: VC6000230412		**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov	**Fax:**
Vendor Code Address ID (e.g., "AD001"): AD005. **(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**	☒ **CONTRACT AMENDMENT**
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)	Enter **Current Contract End Date *Prior*** to Amendment: **December 31, 2027.** Enter **Amendment Amount**: $ no change. (or "no change") **AMENDMENT TYPE: (Check one option only. Attach details of amendment changes.)** ☐ **Amendment to Date, Scope or Budget** (Attach updated scope and budget) ☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget) ☐ **Contract Employee** (Attach any updates to scope or budget) ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

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

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.
☒ **Rate Contract.** (No Maximum Obligation) Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)
☐ **Maximum Obligation Contract.** Enter total maximum obligation for total duration of this contract (or ***new*** total if Contract is being amended). $_____.

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

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)
This **Amendment 1** to the Contract with Fallon Community Health Plan, Inc., for its Accountable Care Partnership Plan with Reliant Medical Group, Inc., updates financial and other provisions and replaces certain appendices in the Contract effective April 1, 2023.

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 **April 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:	**AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:**
DocuSigned by: X: Richard Burke A35ACEB6780C47... . Date: 3/28/2023 .	X: Mike Levine Mike Levine (Mar 29, 2023 13:06 EDT) . Date: 03/29/2023 .
(Signature and Date Must Be Captured At Time of Signature)	**(Signature and Date Must Be Captured At Time of Signature)**
Print Name: Richard Burke .	**Print Name:** Mike Levine .
Print Title: President and CEO .	**Print Title:** Assistant Secretary for MassHealth .

AMENDMENT #1

TO THE

ACCOUNTABLE CARE PARTNERSHIP PLAN CONTRACT

FOR THE

MASSHEALTH ACCOUNTABLE CARE ORGANIZATION PROGRAM

WHEREAS, the Executive Office of Health and Human Services ("EOHHS") and the Contractor identified in **Appendix R** ("Contractor") entered into the Contract effective January 1, 2023, and with an Operational Start Date of April 1, 2023, to serve as an Accountable Care Organization, improve the MassHealth Member experience of care, health of the population, and efficiency of the MassHealth program, and provide comprehensive health care coverage to MassHealth Members; and

WHEREAS, in accordance with **Section 5.9** of the Contract, EOHHS and the Contractor desire to amend the Contract effective April 1, 2023; 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:

1. **Section 1, Definitions, Behavioral Health Advisory Council (BHAC),** is hereby amended by deleting "MassHealth-contracted Accountable Care Partnership Plan" and inserting in place thereof "ACPP and MCO".

2. **Section 1, Definitions, Community Partners (CP),** is hereby amended by inserting "and MCOs" after "ACOs".

3. **Section 1, Definitions, Community Partner (CP) Enrollee,** is hereby amended by deleting "-Assigned" after "BH CP".

4. **Section 1, Definitions, Crisis Prevention Plan**, is hereby amended by deleting "an ESP" and inserting in place thereof "a CBHC".

5. **Section 1, Definitions, EPSDT Periodicity Schedule (or Schedule)**, is hereby amended by deleting "**Appendix S**" and inserting in place thereof "Appendix W".

6. **Section 1, Definitions**, is hereby amended by adding the following definitions in alphabetical order:

   "**Primary Care Sub-Capitation Program** – an EOHHS-specified primary care initiative, as described in **Section 2.23.A** and **Appendix K**.

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

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

7. **Section 2.3.A.2.h** is hereby amended by adding "Each vacant position must be filled within 4 months, except under special circumstances as further approved by EOHHS. Key contacts may serve more than one role. For all other positions, a single individual may temporarily serve more than one role until dedicated permanent staff are hired." at the end of the first paragraph.

8. **Section 2.4.F.5** is hereby amended by deleting "and" before "MassHealth PCACOs" and inserting ", and MassHealth MCOs" after "PCACOs".

9. **Section 2.4.F** is hereby amended by deleting **Section 2.4.F.7** in its entirety and inserting in place thereof a new **Section 2.4.F.7** as follows:

   "7. Shall comply with all requirements set forth in this **Section 2.4.F** and in 42 CFR 438.62(b)(1)-(2)."

10. **Section 2.4.F** is hereby amended by inserting a new **Section 2.4.F.8** as follows:

    "8. Shall maintain continuity of CP supports in accordance with **Section 2.6.E.15**."

11. **Section 2.5.B.3.c** is hereby amended by deleting **Section 2.5.B.3.c.5** in its entirety and inserting in place thereof a new **Section 2.5.B.3.c.5** as follows:

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

12. **Section 2.6.E.6.1** is hereby amended by deleting "Graduated from the CP" and inserting in place thereof "successfully completed Graduation from CP Program".

13. **Section 2.6.E.6** is hereby amended by renumbering **Sections 2.6.E.6.1, 2.6.E.6.2, 2.6.E.6.3, 2.6.E.6.4, 2.6.E.6.5,** and **2.6.E.6.6** to be **Sections 2.6.E.6.a, 2.6.E.6.b, 2.6.E.6.c, 2.6.E.6.d, 2.6.E.6.e,** and **2.6.E.6.f**.

14. **Section 2.6.E.9.a** is hereby amended by deleting "," after "The Contractor shall pay its CPs a panel-based payment" and inserting in place thereof "as set forth in **Appendix P** and" and adding "as set forth in **Appendix P** and" after "homelessness add-on".

15. **Section 2.6.E.9.b** is hereby amended by adding "as set forth in **Appendix P** and" after "payments to CPs".

16. **Section 2.6.E** is hereby amended by adding a new **Section 2.6.E.14** as follows:

"14. When directed by EOHHS, the Contractor shall ensure that BH CPs provide care coordination supports to certain Enrollees who screen positive on Preadmission Screening and Resident Review Level II as further specified by EOHHS."

17. **Section 2.6.E** is hereby amended by adding a new **Section 2.6.E.15** as follows:

"15. Continuity of CP Supports

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

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

18. **Section 2.7.A.2.a** is hereby amended by deleting ";" at the end of the section and inserting in place thereof "and/or disability;".

19. **Section 2.7.B.9.a** is hereby amended by inserting "and for the time period specified by EOHHS" after "set forth by EOHHS".

20. **Section 2.7.D.3.g** is hereby amended by deleting "ESPs" and inserting in place thereof "CBHCs".

21. **Section 2.7.G.3** is hereby amended by deleting "." at the end of the section and inserting in place thereof "or what appears to be an Emergency Medical Condition but does not have the outcomes specified in the definition in **Section 1**."

22. **Section 2.7.G** is hereby amended by adding a new **Section 2.7.G.9** as follows:

"9. The Contractor shall not pay for any item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not included in **Appendix C** as an ACO Covered Service."

23. **Sections 2.7.H** is hereby amended by deleting "calendar year" in each case it appears and inserting in place thereof "Contract Year".

24. **Section 2.8.A.1.b.1** is hereby amended by inserting "in accordance with 42 CFR 438.602(b)" before ";".

25. **Section 2.8.A.1.b.2** is hereby amended by inserting "shall comply with 42 CFR 438.602(b)(2) and therefore" before "may execute Provider Contracts".

26. **Section 2.8.A.3.e.5** is hereby amended by inserting "all" before "contracted CBHCs".

27. **Section 2.8.A.3.i** is hereby amended by deleting "in a manner as directed by EOHHS, including but not limited to using bundled payments" and inserting in place thereof, "CBHCs no less than the payment rates established by EOHHS in 101 CMR 305.000 and shall use procedure codes as directed by EOHHS to provide payment for services rendered by CBHCs".

28. **Section 2.8.D.7.g** is hereby amended by inserting "Pregnancy Enhanced RRS," immediately following "Youth RRS,".

29. **Section 2.9.H** is hereby amended by inserting a new **Section 2.9.H.10** as follows:

"10. Board Certification Requirements

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

a. Require that all applicant physicians, as a condition for participation in the Contractor's Network, meet one of the following, except as otherwise set forth in paragraph b. below:

1) Be board certified in their practicing medical specialty;

2) Be in the process of achieving initial certification; or

3) Provide documentation demonstrating that the physician either is currently board eligible or has been board eligible in the past.

b. If necessary to ensure adequate access, the Contractor may contract with Providers who have training consistent with board eligibility but are neither board certified nor were ever eligible to be board certified. In such circumstances, the Contractor shall submit to EOHHS for review and approval, on a case-by-case basis, documentation describing the access need that the Contractor is trying to address; and

c. Provide a mechanism to monitor participating physician compliance with the Contractor's board certification requirements, including, but not limited to, participating physicians who do not achieve board certification eligibility."

30. **Section 2.9.L.3** is hereby amended by deleting "make value-based payments within 3 days of receiving payment from EOHHS," and inserting in place thereof the following: "make timely value-based payments".

31. **Section 2.9.M.3** is hereby amended by inserting "timely" before "value-based payments" and deleting "The Contractor shall make such payments to such Providers within 14 calendar days of receiving payment from EOHHS.".

32. **Section 2.9.N.3** is hereby amended by inserting "payments" after "value-based".

33. **Section 2.9** is hereby amended by adding a new **Section 2.9.R** as follows:

"R. Directed Payments – General Requirement

All directed payments set forth in this Contract pursuant to 42 CFR 438.6(c)(1)(i)-(iii) shall comply with the requirements in 42 CFR 438.6(c)(2)."

34. **Section 2.10.C.1.d.2** is hereby amended by deleting "in" after "set forth".

35. **Section 2.10.C.5.b.2** is hereby amended by deleting ", including but not limited to providers of ESP Services".

36. **Section 2.12.F** is hereby amended by deleting the section in its entirety and inserting in place thereof the following new **Section 2.12.F**:

"F. MassHealth Benefit Request and Eligibility Redetermination Assistance

1. As directed by EOHHS, the Contractor or Provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:

a. Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants;

b. Assist MassHealth applicants in completing and submitting MBRs;

c. Offer to assist Enrollees with completion of the annual ERV form; and

d. Refer MassHealth applicants to the MassHealth Customer Service Center

2. The Contractor is authorized and directed to communicate with Enrollees to help them renew their MassHealth coverage. The Contractor is authorized and directed to make appropriate use of prerecorded or artificial autodialed calls and automated texts in compliance with the Federal Communications Commission January 23, 2023, Declaratory Ruling. The Contractor shall consult its legal counsel about the appropriate use of autodialed calls and automated texts to Enrollees pursuant to the FCC Declaratory Ruling. The Contractor shall be responsible for complying with the ruling."

37. **Section 2.14.C.1.c.2** is hereby amended by adding ", starting in Contract Year 2 (i.e., 2024)," after "The Contractor shall".

38. **Section 2.15.C.1.c** is hereby amended by deleting ";" at the end of the section and inserting in place thereof the following: "and reflects all dates of service through the end of the Contract."

39. **Section 2.15.G.7** is hereby amended by adding "[Reserved]".

40. **Section 2.15.G.9** is hereby amended by renumbering **Sections 2.15.G.9.c, 2.15.G.9.d, 2.15.G.9.e.** and **2.15.G.9.f** to be **Sections 2.15.G.9.d, 2.15.G.9.e, 2.15.G.9.f,** and **2.15.G.9.g** and inserting a new **Section 2.15.G.9.c** as follows:

    "c. Provider contracts;"

41. **Section 2.23** is hereby amended by adding a new **Section 2.23.C** as follows:

    "C. Directed Payments Related to Certain ACO Covered Services

    The Contractor shall institute the rate increases as set forth in this section and **Appendix S** and as further described in MassHealth's Managed Care Entity Bulletins, as may be updated from time to time and as follows. The Contractor shall:

    1. Increase payment rates temporarily to providers as specified in this section and as set forth in **Appendix S**.

        a. The Contractor shall apply the percentage increases indicated in the table in **Appendix S** to the Contractor's contracted rates as of June 30, 2021; provided, however, that the Contractor shall apply the percentage increases indicated in the table in **Appendix S** to the Contractor's contracted rates as of July 1, 2021**,** for Acute Treatment Services (ATS), Clinical Support Services (CSS), Residential Rehabilitation Services (RRS), Program for Assertive Community Treatment, Psychotherapy (60 minute) services, and Behavioral Health Day Treatment (Psychiatric Day Treatment) services. All rate increases shall apply regardless of whether those rates are the same as the MassHealth fee-for-service rates. For any service already subject to a directed payment requirement, the Contractor shall apply the rate increases set forth in **Appendix S** to the directed payment amount set forth in the Contract.

        b. If the Contractor has sub-capitated or Alternative Payment Methodology (APM) arrangements with providers for the provision of any services subject to rate increases pursuant to this section, the sub-capitated or APM payments to providers should be increased by the equivalent of the rate increases that would be required for fee for service payments as set forth in this section.

c. The Contractor shall not subject the required rate increases to any withhold arrangement with providers. The Contractor shall ensure that providers receive the full rate increases in payments made for the services listed in **Appendix S**.

d. All encounter file claim paid amounts with dates of service between the rate increase effective date and the rate increase end date must reflect the specified rate increases having been paid by plans to eligible providers.

2. Ensure that its providers receiving the rate increases set forth in **Appendix S** use at least 90% of the rate increase to support HCBS and behavioral health direct care and support staff as specified by EOHHS and consistent with any eligible provider list provided by EOHHS.

3. Ensure that its providers receiving the rate increases use this funding for the specific allowable purposes of recruiting, building, and retaining their direct care, clinical, and support workforce as specified by EOHHS.

4. Ensure that its providers receiving the rate increases complete and submit EOHHS-required attestations and spending reports as specified by EOHHS. The Contractor shall inform such providers that failure to comply with the attestation and spending report requirement may subject the provider to financial penalty.

5. Certify on a monthly basis in a form and format specified by EOHHS to compliance with the rate increase requirements described in this section."

42. **Section 3.1.B.2** is hereby amended by deleting "Accountable Care Partnership Plan average" and inserting in place thereof "managed care plan average, as appropriate".

43. **Section 3.3.C.1.a.2** is hereby amended by deleting ";" and inserting in place thereof the following:

    ". In the case that EOHHS fails to make a disenrollment determination for an Enrollee by the first day of the second month following the month in which the Enrollee requests disenrollment or the Contractor refers the request to the state, the disenrollment shall be considered approved for the effective date that would have been established had EOHHS made a determination in the specified timeframe;".

44. **Section 3.3.C.1.b.2** is hereby amended by adding "and 130 CMR 508.003(E)(2)." at the end of the section.

45. **Section 3.4.B.6** is hereby amended by deleting "Accountable Care Partnership Plans" and inserting in place thereof "ACOs and MCOs".

46. **Sections 4.3.A.1** and **4.3.A.2** are hereby amended by deleting "**Section 2.9.O"** and inserting in place thereof "**Section 2.9.P**".

47. **Sections 4.3.E.1** and **4.3.E.2** are hereby amended by deleting "**Section 2.9.M.2**" and inserting in place thereof "**Section 2.9.M.3**".

48. **Section 4.3.F.2** is hereby amended by adding "**Section 2.9.N.3**" after "described in".

49. **Section 4.5.D** is hereby amended by deleting **Section 4.5.D.5** in its entirety and inserting in place thereof a new **Section 4.5.D.5** as follows:

"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:

1) 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.

2) In excess of 100% of the Primary Care Sub-Capitation Program Rates for Primary Care Entities set forth in Appendix L, then EOHHS may not reprice such payments. The Contractor shall attest in a form and format specified by EOHHS about such payments.

b. If the Contractor has an approved Alternative Payment Methodology (APM) for the purposes of Base Capitation Rate development ("Approved APM") and EOHHS reprices the Contractor's paid Claims in accordance with **Section 4.5.D.5.a.1**, EOHHS shall:

1) Request an attestation from the Contractor that contains the following information:

a) Approved APM expenditures in excess of EOHHS's fee schedule accrued during the Contract Year; and

b) That the APM active during the Contract Year is either the same as or materially similar to the Approved APM. Material similarity shall be determined by EOHHS.

2) Apply an adjustment to the Contractor's repriced paid Claims as follows:

a) Such adjustment shall be equal to the lesser of:

(i) The Approved APM adjustment applied during Base Capitation Rate development or

(ii) The Approved APM expenditures in excess of EOHHS's fee schedule accrued during the Contract Year as attested to by the Contractor as specified in **Section 4.5.D.5.b.1.a.**

b) EOHHS shall not include as part of such adjustment the amount of any payments the Contractor makes under the Primary Care Sub-Capitation Program.

c. If 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."

50. **Sections 4.6.A.3.c** and **4.6.F.2.c** are hereby amended by adding "under the same terms of performance" before ";" in each case.

51. **Sections 4.6.B.1** and **4.6.C** are hereby amended by deleting "two" and inserting in place thereof "0.75".

52. **Section 5.1.O.2.a** is hereby amended by deleting "providers" and inserting in place thereof "individuals" and inserting "by conducting routine checks of federal databases" after "good stead".

53. **Section 5.7** is hereby amended by deleting "resulting from this RFR".

54. **Appendix A, ACO Reporting Requirements**, is hereby deleted and replaced with the attached **Appendix A**.

55. **Appendix B, Quality Improvement Goals, Section 5** is hereby amended by deleting "this of" after "modify".

56. **Appendix C, ACO Covered Services**, is hereby deleted and replaced with the attached **Appendix C**.

57. **Appendix D, Payment,** is hereby deleted and replaced with the attached **Appendix D**.

58. **Appendix K, Primary Care Sub-Capitation Program**, is hereby deleted and replaced with the attached **Appendix K.**

59. **Appendix L, Sub-Capitation Program Rates for Primary Care Entities,** is hereby deleted and replaced with the attached **Appendix L**.

60. **Appendix N, Network Availability Standards,** is hereby deleted and replaced with the attached **Appendix N**.

61. **Appendix O, Behavioral Health and Certain Other Services Minimum Fee Schedule**, is hereby deleted and replaced with the attached **Appendix O**.

62. **Appendix P, Requirements for the Material Subcontracts Between Accountable Care Organizations (ACOs) and Community Partners (CPs),** is hereby deleted and replaced with the attached **Appendix P**.

63. **Appendix Q, EOHHS Accountable Care Organization Quality and Health Equity Appendix,** is hereby deleted and replaced with the attached **Appendix Q**.

64. **Appendix S, Directed Payments Related to Certain ACO Covered Services,** is hereby deleted and replaced with the attached **Appendix S**.

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 and Checklist** Notification of Intention to Use a New Material Subcontractor and Checklist (Material Subcontract Checklist must be submitted no later than 60 days prior to requested implementation date)	Ad-Hoc	OnBase
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-29	**CM-29 Encounter Data Submission (Appendix E)** Encounter Data Submission (Appendix E)	Monthly	Data Warehouse
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-57	**[RESERVED]**		
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annually	OnBase

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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
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 Homeless Individuals Provider List** Community Support Program for 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
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	SFTP
CC-07-B	**CC-07-B CP Payment Receipts** CP Payment Receipts	Monthly	SFTP
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	SFTP
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
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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]**		
FR-43	**FR-43 Primary Care Sub-Capitation Payment Tracking Report** Primary Care Sub-Capitation Payment Tracking Report	Monthly	SFTP
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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 Report	Ad-Hoc	OnBase
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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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
PH-20	**[RETIRED]**		
PH-21	**PH-21 reSET and reSET-O Utilization** reSET and reSET-O Utilization *(Note: Due by the last business day of the second month following the end of each quarter)*	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	Ad-Hoc	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
PH-24	**PH-24 Oxlumo Monitoring Program** Oxlumo Monitoring Program	Quarterly	OnBase
PH-25	**PH-25 Amyloidosis Therapies Monitoring Program** **Amyloidosis Therapies Monitoring Program** -Quarterly	Quarterly	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
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 QM/QI Program Description/Workplan** Report needs to be submitted as per Appendix B, Quality Improvement Goals.	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
QR-07	**QR-07 Clinical Quality Measures**	Annually	Quality Vendor
QR-08	**QR-08 Supplemental Data for Clinical Quality and Health Equity Measures** Supplemental data files (Format for submission determined and communicated by MassHealth's Comprehensive Quality Measure Vendor (CQMV).	Annually	Inter-change
QR-09	**QR-09 Validation of Performance Measures** Performance Measure Data (Format for submission determined and communicated by External Quality Review Organization).	Annually	EQRO
QR-10	**QR-10 Performance Improvement Projects** Performance Improvement Project Reports (Format for submission determined by and communicated by External Quality Review Organization).	Bi-Annually	EQRO

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-11	**QR-11 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-12	**QR-12 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 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.	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Certain COVID-19 Specimen Collection and Testing – until May 11, 2023, 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.	✓	✓	✓

	Coverage Types		
Service	**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,	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
home health aide, and occupational, physical, and speech/language therapy. See CMR 403.000 and MassHealth Home Health Agency Bulletin 54 (June 2019).			
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	✓		

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**
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 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	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
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.	✓	✓	✓
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.	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
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. **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	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
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.	✓		

	Coverage Types		
Service	**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.	✓		
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 objectives. Goals and objectives are outlined on a day habilitation service plan and are	✓		

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
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.	✓		
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.	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
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.	✓		✓
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

Service	Coverage Types		
	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)**			

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
24-Hour Diversionary Services:			
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,	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
outreach to families and significant others, linkage to medications for addiction therapy, connection to primary care and community supports and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. 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	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.			
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	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.			
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	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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 Enrollees with Justice Involvement who have a barrier to accessing or 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 Enrollees 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 Enrollees 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. The primary goal of the CSP-TPP is to preserve the tenancy and the secondary goals are to put in place services that address those issues that put the Enrollee's housing in jeopardy to ensure that the Enrollee'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.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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 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.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	**ACO MassHealth Family Assistance Enrollees**	**CarePlus**
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.	✓	✓	✓
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.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
b. Case Consultation - an in-person or by telephone meeting of at least 15 minutes' duration, between the treating Provider and other behavioral health clinicians or the Enrollee's primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.	✓	✓	✓
c. Diagnostic Evaluation - an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.	✓	✓	✓
d. Dialectical Behavioral Therapy (DBT) - a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Enrollees with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.	✓	✓	✓
e. Psychiatric Consultation on an Inpatient Medical Unit - an in- person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.	✓	✓	✓
f. Medication Visit - an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
g. Couples/Family Treatment - the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.	✓	✓	✓
h. Group Treatment – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.	✓	✓	✓
i. Individual Treatment - the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.	✓	✓	✓
j. Inpatient-Outpatient Bridge Visit - a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.	✓	✓	✓
k. 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.	✓	✓	

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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 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	✓	✓	

	Coverage Types		
Service	**ACO MassHealth Standard & CommonHealth Enrollees**	**ACO MassHealth Family Assistance Enrollees**	**CarePlus**
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.	✓	✓	
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.	✓	✓	

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	**ACO MassHealth Family Assistance Enrollees**	**CarePlus**
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 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	✓		

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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 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	✓	✓	

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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)**			
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	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
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. **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.			

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	**ACO MassHealth Family Assistance Enrollees**	**CarePlus**
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
Rate Year 2023

Listed below are the Per Member Per Month (PMPM) Base Capitation Rates for Rate Year 2023 (April 1, 2023, through December 31, 2023) (also referred to as 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 April 1, 2023 – 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	$562.95	$45.62	$608.57
Greater Boston	$573.53	$46.78	$620.31
Southern	$601.27	$47.25	$648.52
Central	$556.22	$46.51	$602.73
Western	$514.48	$45.00	$559.48

ACPP Base Capitation Rates / RC I Child			
Effective April 1, 2023 – 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	$247.83	$33.07	$280.90
Greater Boston	$255.24	$34.37	$289.61
Southern	$259.98	$34.00	$293.98
Central	$261.32	$33.61	$294.93
Western	$268.17	$34.53	$302.70

ACPP Base Capitation Rates / RC II Adult			
Effective April 1, 2023 – 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	$1,936.63	$105.81	$2,042.44
Greater Boston	$2,048.31	$113.59	$2,161.90
Southern	$2,003.05	$107.85	$2,110.90
Central	$1,893.90	$105.89	$1,999.79
Western	$1,639.71	$95.15	$1,734.86

ACPP Base Capitation Rates / RC II Child			
Effective April 1, 2023 – 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	$1,214.64	$96.95	$1,311.59
Greater Boston	$1,218.02	$104.49	$1,322.51
Southern	$1,131.22	$94.77	$1,225.99
Central	$1,033.72	$88.19	$1,121.91
Western	$864.10	$76.81	$940.91

ACPP Base Capitation Rates / RC IX			
Effective April 1, 2023 – 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	$601.68	$47.41	$649.09
Greater Boston	$587.88	$47.70	$635.58
Southern	$670.65	$50.77	$721.42
Central	$632.63	$49.38	$682.01
Western	$586.68	$47.72	$634.40

ACPP Base Capitation Rates / RC X			
Effective April 1, 2023 – 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	$1,963.04	$104.57	$2,067.61
Greater Boston	$2,058.01	$110.72	$2,168.73
Southern	$1,827.32	$100.12	$1,927.44
Central	$1,703.64	$95.88	$1,799.52
Western	$1,483.52	$85.73	$1,569.25

High Cost Drug Add-On to Risk Adjusted Capitation Rates
Effective April 1, 2023 – 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	**$5.93**	**$3.28**	**$1.69**	**$5.45**	**$0.41**
RC I Child	**$6.02**	**$6.05**	**$3.86**	**$2.71**	**$2.69**
RC II Adult	**$18.15**	**$11.30**	**$16.76**	**$62.89**	**$22.08**
RC II Child	**$64.51**	**$133.30**	**$21.26**	**$116.34**	**$29.65**
RC IX	**$6.52**	**$9.15**	**$5.31**	**$15.12**	**$4.84**
RC X	**$2.95**	**$4.13**	**$4.61**	**$1.51**	**$1.52**

ABA Add-On to Risk Adjusted Capitation Rates
Effective April 1, 2023 – 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 April 1, 2023 – December 31, 2023 (RY23)

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Adult	**$6.31**
RC-I Child	**$0.30**
RC-II Adult	**$18.57**
RC-II Child	**$0.49**
RC-IX	**$13.81**
RC-X	**$173.92**

EXHIBIT 2
ADJUSTMENTS OR ADDITIONS TO PAYMENTS
Rate Year 2023

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
Rate Year 2023

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 Loss 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**

   If the actual High Cost Drug expenditures, as determined by EOHHS in accordance with **Section 4.5.F.3**, is greater than or less than the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment for the Contract Year, as determined by EOHHS in accordance with **Section 4.5.F.2**, the Contractor and EOHHS shall share the resulting loss or gain as follows:

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**

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%

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.

SECTION II: Tier 2 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 2. Practices shall meet ***all Tier 1 requirements and all Tier 2 requirements*** to achieve this Tier Designation.

A. Care Delivery

The practice shall:

☐ Brief intervention for BH conditions: Provide brief interventions for patients with identified BH needs, as appropriate, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), brief Cognitive Behavioral Therapy (CBT), or an equivalent model. These may be provided by a front-line clinical provider or by an integrated member of the clinical team, such as a licensed independent clinical social worker (LICSW). While practices may offer some BH interventions for BH conditions virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Telehealth-capable BH referral partner: Include at least one BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network.

B. Structure and Staffing

The practice shall:

☐ E-consults available in at least three (3) specialties: be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the practice to discuss with specialists in at least three distinct and non-redundant American Board of Medical Specialties (ABMS)-recognized specialties. For example, offering e-consults to multiple specialties with board certification under the pathways of Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, seeking to count e-consults in general cardiology, clinical cardiac electrophysiology, and interventional cardiology as three distinct specialties would not meet this requirement.

☐ After-hours or weekend session: offer at least four hours for in-person or telehealth visits, with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, at least once per week within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice for this coverage, EOHHS encourages the Contractor to utilize practices that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

☐ Team-based staff role: maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles:

- Community health worker (CHW)
- Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
- Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
- Nurse case manager

Such team-based role shall:

- Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., ≥0.3 FTE) per week,
- Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

☐ Maintain a consulting independent BH clinician: maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above.

- This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care.
- This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two business days.

C. Population Specific Expectations

Practices serving Enrollees 21 years of age or younger shall:

☐ Staff with children, youth, and family-specific expertise: identify at least one non-clinical team member with demonstrable experience addressing the BH and HRSN of children, youth, and families in a health care setting and/or possessing specialized training, degree, licensing, or certification in such work. This role may be met virtually but shall be on-site at least monthly. This role shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, Family Resource Centers (FRCs), and schools/early childhood settings.

☐ Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site.

Practices serving Enrollees ages 21-65 shall:

☐ LARC provision, at least one option: have the on-site ability to place at least one (1) type of long-acting reversible contraceptive (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). This activity may occur either in the primary care office or from a co-located provider at the same practice site. Enrollees must be able to access this requirement on-site.

☐ Active Buprenorphine Availability: have at least one (1) individual provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder as

clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for Enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service, without having to refer the Enrollee to another location. This provider shall be dedicated and available to patients in the practice on-site or virtually on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices that require the Enrollee to present at a different location does not meet this requirement.

☐ Active Alcohol Use Disorder (AUD) Treatment Availability: at least one provider actively prescribing or willing and able to prescribe relevant medications for management of alcohol use disorder (e.g., Disulfiram, Acamprosate, Naltrexone, etc.). This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

SECTION III: Tier 3 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 3. Practices shall meet *all Tier 1 requirements, all Tier 2 requirements, and all Tier 3 requirements* to achieve this Tier Designation.

A. Care Delivery

*The practice shall fulfill at least **one** of the following three requirements:*

☐ Clinical pharmacist visits: offer its patients the ability to conduct office-based or virtual appointments with a licensed clinical pharmacist focused on medication management and teaching. This role may conduct its activities virtually. The clinical pharmacist shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE)

OR

☐ Group visits: offer its patients the ability to participate in office-based or virtual appointments at which services are provided to multiple patients for a shared condition and peer support is elicited (e.g., mental health, substance use disorder, antenatal care, etc.). These visits may be conducted virtually. Group visits shall be offered by staff that are dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE)

OR

☐ Designated Educational Liaison for pediatric patients: For practices serving pediatric patients, have dedicated staff member that serves as an office-based or virtual resource for families navigating the intersection of the medical and educational systems. This role may conduct its activities virtually. The Educational Liaison shall have knowledge of education and special education systems, including early education settings, and shall create relationships with local schools and early education settings. The Educational Liaison shall provide support to patients with medical, developmental, and/or BH needs and shall be available to provide input to the educational team at schools as needed and shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE).

B. Structure and Staffing

The practice shall:

☐ E-consults available in at least five (5) specialties: be capable of asynchronous, consultative, provider-to-provider communications within a shared EHR or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the primary care practice to discuss with specialists in at least five (5) distinct and non-redundant ABMS-recognized specialties. For example, offering e-consults to multiple specialties with board certification under Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, general cardiology, clinical cardiac electrophysiology, and interventional cardiology would not meet this requirement.

☐ After-hours or weekend session: offer at least 12 hours for in-person or telehealth visits with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, falling within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period of at least four hours

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice site may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice site for this coverage, EOHHS encourages the Contractor to utilize practice sites that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. At least 4 hours shall be in-person. At least 4 hours must fall on a weekend day. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

☐ Three team-based staff roles: maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following:

- At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW)
- At least one (1) staff role shall be a peer, family navigator, CHW, or similar.
- The other staff role(s) may be one of the following, or similar:
  - Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
  - Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
  - Nurse case manager

Such team-based roles shall:

- Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥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). The table below sets forth PMPM amounts by PCE, across all Regions and Rating Categories. 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			
April 1, 2023 – 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]	**$ 20.05**	**$ 11.62**	**$ 31.67**

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	30	15

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	40	20
Audiology	1	40	20
Cardiology	1	40	20
Dermatology	1	40	20
Emergency Medicine	1	40	20
Endocrinology	1	40	20
Gastroenterology	1	40	20
General Surgery	1	40	20
Hematology	1	40	20
Infectious Disease	1	40	20
Medical Oncology	1	40	20
Nephrology	1	40	20
Neurology	1	40	20
Ophthalmology	1	40	20
Oral Surgery	1	-	-
Orthopedic Surgery	1	40	20
Otolaryngology	1	40	20
Physiatry	1	40	20
Plastic Surgery	1	-	-
Podiatry	1	40	20
Psychiatry	1	40	20
Pulmonology	1	40	20
Rheumatology	1	40	20
Urology	1	40	20
Vascular Surgery	1	-	-

For Oaks Bluff and Nantucket Service Areas only, the Contractor shall have at least one Provider in the above specialties, excluding Allergy, Oral Surgery, Plastic Surgery, and Vascular Surgery, 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
MH and SA OP Services	90837	AH - Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 127.53

* 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	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
MH and SA OP Services	99212	U6 - Doctoral Level (MD / DO)	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	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
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

* 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	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
MH and SA OP Services	99281	U6 - Doctoral Level (MD / DO)	o	$ 20.14
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.	$ 35.37

* 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	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.	$ 33.68
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.	$ 32.70
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.	$ 53.52
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.	$ 50.97
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.	$ 49.49

* 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	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.	$ 100.58
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.	$ 95.80
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.	$ 93.01
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.	$ 148.78

* 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	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.	$ 141.69
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.	$ 136.30
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
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	H0037	U2-Autism Diagnosis	Community Psychiatric Supportive Treatment Program, per diem (CBAT Autism Speciality)	$ 1,093.70
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

* 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**
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	H2015	+	Comprehensive community support services, per 15 minutes (Community Support Program)	101 CMR 362.00
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	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.)	$ 695.29
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

* 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**
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
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
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

* 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**
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
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	H0046	HE-Mental Health Program	Mental health services, not otherwise specified (Certified Peer Specialist)	101 CMR 305
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
MH and SA OP Services	H0004		Behavioral health counseling and therapy, per 15 minutes (individual counseling)	101 CMR 346

* 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	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
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

* 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 Contractor shall pay CPs a monthly panel-based payment that includes the following components, and as further specified by EOHHS.

    a. Base rate for CP Supports: $190 PMPM or a rate as further specified by EOHHS

    b. Add-on payment for CPs serving Enrollees who are experiencing homelessness, as determined by EOHHS. The Contractor shall make an add-on payment to applicable CPs as follows:

        (i) Tier 1: 30-60% of the CP's enrollees are experiencing homelessness – The Contractor shall pay an additional $10 PMPM for all Enrollees enrolled in the CP

        (ii) Tier 2: Over 60% of the CP's enrollees are experiencing homelessness - The Contractor shall pay an additional $75 PMPM for all Enrollees enrolled in the CP)

(iii) The percentage of a CP's enrollees that are experiencing homelessness will be determined by EOHHS identified sources.

2. The Contractor shall pay CPs an annual quality performance-based payment based on calculations provided by EOHHS up to $40 PMPM based on the CP's performance on CP Quality Measures, as determined by EOHHS.

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 for a contract or other arrangement with a Business Associate under the Privacy and Security Rules, includes any terms and conditions required under a data use agreement between the Contractor and EOHHS and otherwise complies with any other privacy and security laws, regulations and legal obligations to which the Contractor is subject;
2. Include such agreement as an appendix to the subcontract;
3. Specify that no Party to the subcontract may obligate the other Party to use a specific Information Technology, Electronic Health Record system, or Care Management system;
4. Obligate both Parties to develop, maintain, and implement a mutually agreed processes for the exchange of 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 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 and Health Equity Performance and Scoring
2. Scoring Methodology for ACO Quality Score
    a. List of Quality Measures for ACO Quality Score
    b. Measure Level Scoring Methodology (Achievement and Improvement Points
    c. Domain Level Scoring Methodology
3. Scoring Methodology for ACO Health Equity Score
4. Scoring Methodology for Community Partners Quality Score
    a. List of Quality Measures for CP Quality Score
5. Methodology for Establishing Performance Benchmarks for Quality Measures
6. Quality and Health Equity Performance Financial Application

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 1	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Preventive and Pediatric Care	Developmental Screening in the First 3 Years of Life	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Claims/ Hybrid	OHSU	1448	2025
	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	NCQA	1407	2024
	Childhood Immunization Status	Percentage of members 2 years of age who received all recommended vaccines by their second birthday	Hybrid	NCQA	0038	2024
	Prenatal and Postpartum Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment Percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery	Hybrid	NCQA	N/A	2023

Domain 1	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
	Topical Fluoride for Children, Dental or Oral Health Services	Percentage of children aged 1–20 years who received at least 2 topical fluoride applications as dental or oral health services within the reporting year	Claims	ADA DQA	3700	2024
	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Hybrid	CMS	0418	2023

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Care Coordination/ Care for Acute and Chronic Conditions	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 days	Claims	NCQA	3489	2023
	Follow-Up After Emergency Department Visit for Alcohol and Other	Percentage of emergency department (ED) visits for members 13 years of age and older with a principal	Claims	NCQA	3488	2023

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
	Drug Abuse or Dependence (7 days)	diagnosis of AOD abuse or dependence, who has a follow up visit for AOD				
	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576	2023
	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	NCQA	0018	2024
	Comprehensive Diabetes Care: HBA1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059	2024
	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800	2024
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate	Claims	NCQA	0004	2024

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
		treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit				
Member Experience	Overall Care Delivery	Composites related to overall experience (e.g., Willingness to Recommend, Communications)	Survey	AHRQ	N/A	2023
	Person-Centered Coordination/Integration of Care	Composites related to coordination of care (e.g., referrals, services etc.) and knowledge of the patient	Survey	AHRQ	N/A	2023

Exhibit 2.A – ACO Quality Measures: Pediatric Replacement Measures

Domain	Measure Name	Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Care Coordination/Care for Acute and Chronic Conditions	Metabolic Monitoring for Children and Adolescents on Antipsychotics *Replacing: Controlling High Blood Pressure* and *Comprehensive Diabetes Care: HBA1c Poor Control*	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Claims	NCQA	2800	2024

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. The Contractor's performance score will be calculated on each Quality Measure based on the measure specifications. Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

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 applicable Quality Measure using the following formula (unless otherwise communicated by EOHHS). The Improvement Target is based on at least a 20% improvement each year in the gap between Goal Benchmark and the Attainment Threshold of each ACO measure.

    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.
Follow-up with BH CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP within x business days of discharge	Claims	EOHHS	NA
Follow-up with BH CP after ED visit (x days)	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within x days of the ED visit	Claims	EOHHS	NA
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA
Initiation/Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	Claims	NCQA	1932
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on	Claims	NCQA	0105

Measure Name	Description	Data Source	Measure Steward	NQF No.
	antidepressant medication treatment			
Treatment Plan Completion	TBD	Claims	EOHHS	NA
Member Experience	TBD	Survey	EOHHS	NA

Exhibit 7 – LTSS CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.
Follow-up with LTSS CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a LTSS CP within x business days of discharge	Claims	EOHHS	NA
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA
Care Plan Completion	TBD	Claims	EOHHS	NA
Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	Claims	ADA	NA
All-Cause ED Visits	The rate of ED visits for enrollees 3 to 64 years of age	Admin	EOHHS	NA
Member Experience	TBD	Survey	EOHHS	NA

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 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	6/30/2023

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
Psychological Testing	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)