COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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CONTRACTOR LEGAL NAME: Steward Medicaid Care Network, 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): 1900 North Pearl St., Suite 2400, Dallas, TX 75201		**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108	
Contract Manager: Jennie Vital	**Phone:** 617-309-0495	**Billing Address (if different):**	
E-Mail: jennie.vital@steward.org	**Fax:**	**Contract Manager:** Alejandro Garcia Davalos	**Phone:** 617-838-3344
Contractor Vendor Code: VC0000854705		**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov	**Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**		**MMARS Doc ID(s):** N/A **RFR/Procurement or Other ID Number:** BD-22-1039-EHS01-ASHWA-71410	

☐ NEW CONTRACT

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

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

☒ CONTRACT AMENDMENT

Enter **Current Contract End Date *Prior*** to Amendment: **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 Steward Medicaid Care Network, Inc. for its Primary Care ACO 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:

X: ___ Joseph M. Weinstein, MD Date: 3/28/2023

(At Time of Signature)

Print Name: Joseph Weinstein, MD

Print Title: President

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: Mike Levine Date: 03/29/2023

Mike Levine (Mar 29, 2023 13:06 EDT)

(Signature and Date Must Be Captured At Time of Signature)

Print Name: Mike Levine

Print Title: Assistant Secretary for MassHealth

AMENDMENT #1

TO THE

PRIMARY CARE ACCOUNTABLE CARE ORGANIZATION CONTRACT

FOR THE

ACCOUNTABLE CARE ORGANIZATION PROGRAM

WHEREAS, the Executive Office of Health and Human Services ("EOHHS") and the Contractor identified in **Appendix K** ("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 5.12** of the Contract, EOHHS and the Contractor desire to amend the Contract effective January 1, 2023;

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

2. **Section 1, Definitions, Community Partner (CP) Enrollee,** is hereby amended by adding "(BH CP Enrollee and LTSS CP Enrollee, respectively)" after "LTSS CP".

3. **Section 1, Definitions, Primary Care Sub-Capitation Payment,** is hereby amended by deleting "fixed fee for each Enrollee" and inserting in place thereof "payment from EOHHS to the Contractor".

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

   "**Primary Care Sub-Capitation Program** – an EOHHS-specified primary care initiative, as described in **Section 2.14.A** and **Appendix D**."

5. **Section 2.3.B.3.c** is hereby amended by deleting **Section 2.3.B.3.c.5** in its entirety and inserting in place thereof a new **Section 2.3.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."

6. **Section 2.4.E.5.e.1** is hereby amended by deleting "Graduated from the CP" and inserting in place thereof "successfully completed Graduation from CP Program".

7. **Section 2.4.E.8.a** is hereby amended by deleting "," and adding "as set forth in **Appendix G** and" after "The Contractor shall pay its CPs a panel-based payment" and adding "as set forth in **Appendix G** and" after "homelessness add-on".

8. **Section 2.4.E.8.b** is hereby amended by adding "as set forth in **Appendix G** and" after "payments to CPs".

9. **Section 2.4.E** is hereby amended by renumbering **Sections 2.4.E.5.e**, **2.4.E.5.e.1, 2.4.E.5.e.2, 2.4.E.5.e.3, 2.4.E.5.e.4, 2.4.E.5.e.5, 2.4.E.5.e.6, 2.4.E.6**, **2.4.E.7**, **2.4.E.8, 2.4.E.9, 2.4.E.10, 2.4.E.11,** and **2.4.E.12** to be **Sections 2.4.E.6**, **2.4.E.6.a, 2.4.E.6.b, 2.4.E.6.c, 2.4.E.6.d, 2.4.E.6.e, 2.4.E.6.f, 2.4.E.7**, **2.4.E.8**, **2.4.E.9**, **2.4.E.10, 2.4.E.11, 2.4.E.12,** and **2.4.E.13**.

10. **Section 2.4.E** is hereby amended by adding a new **Section 2.4.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."

11. **Section 2.4.E** is hereby amended by adding a new **Section 2.4.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."

12. **Section 2.5.B.2** is hereby amended by renumbering **Sections 2.5.B.2.b, 2.5.B.2.c,** and **2.5.B.2.d** to be **Sections 2.5.B.2.c, 2.5.B.2.d**, and **2.5.B.2.e** and inserting a new **Section 2.5.B.2.b** as follows:

"b. Provider contracts;"

13. **Section 2.7.G** is hereby amended by deleting the section in its entirety and inserting in place thereof the following new **Section 2.7.G**:

    "G. 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. If directed by EOHHS, the Contractor is authorized 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."

14. **Section 2.14.A.1.i.3** is hereby amended by deleting "The Contractor shall coordinate" and inserting in place thereof "Coordinate" and deleting "." at the end of the section and inserting in place thereof ";".

15. **Section 2.14.A.1.i.4** is hereby amended by deleting "The Contractor shall report" and inserting in place thereof "Report".

16. **Section 3.3.D.2** is hereby amended by deleting "." and inserting in place thereof "and 130 CMR 508.003(E)(2).".

17. **Section 3.3** is hereby amended by adding a new **Section 3.3.E** as follows:

    "E. 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."

18. **Sections 4.2.C.2** and **4.2.C.3** are hereby amended by deleting "two" and inserting in place thereof "0.75".

19. **Section 5.26.A.1** is hereby amended by deleting "providers" and inserting in place thereof "individuals" and inserting "by conducting routine checks of federal databases" after "good stead".

20. **Appendix A, TCOC Included Services**, is hereby deleted and replaced with the attached **Appendix A**.

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

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

23. **Appendix F, ACO Reporting Requirements**, is hereby deleted and replaced with the attached **Appendix F**.

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

25. **Appendix I, TCOC Benchmarks**, is hereby deleted and replaced with the attached **Appendix I**.

26. **Appendix J, Sub-Capitation Program Rate for Primary Care Entities**, is hereby deleted and replaced with the attached **Appendix J**.

APPENDIX A

Exhibit 1: Services Included in TCOC Calculations

✓ Denotes a service included in TCOC Calculations

Each of the Services listed below will be included in Total Cost of Care (TCOC) calculations, except for those listed as Services Not Included in TCOC Calculations or listed as Excluded Services. MassHealth reserves the right to amend or modify this list, including but not limited to further defining the services listed below as well as adding or removing services.

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Acupuncture Treatment	✓	✓	✓
Acute Inpatient Hospital	✓	✓	✓
Ambulatory Surgery/Outpatient Hospital Care	✓	✓	✓
Audiologist	✓	✓	✓
Behavioral Health Services (see below)	✓	✓	✓
Breast Pumps	✓	✓	✓
Certain COVID-19 Specimen Collection and Testing (until May 11, 2023)	✓	✓	✓
Chiropractic Services	✓	✓	✓
Chronic, Rehabilitation Hospital or Nursing Facility Services, up to 100 days per Contract Year, except stays in Commonwealth designated COVID-19 nursing facility, see non-TCOC Included Services in Exhibit 2.	✓	✓	✓
Emergency Related Dental Services	✓	✓	✓
Diabetes Self-Management Training	✓	✓	✓
Dialysis	✓	✓	✓
Durable Medical Equipment and Medical/Surgical Supplies **1) Durable Medical Equipment** **2) Medical/Surgical Supplies**	✓	✓	✓
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	✓		
Early Intervention	✓	✓	

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Emergency Services	✓	✓	✓
Family Planning	✓	✓	✓
Fluoride Varnish	✓	✓	
Hearing Aids	✓	✓	✓
Home Health Services	✓	✓	✓
Hospice	✓	✓	✓
Infertility, related to an underlying medical condition	✓	✓	✓
Laboratory	✓	✓	✓
MassHealth Coordinating Aligned, Relationship-centered Enhanced Support (CARES) for Kids	✓		
Medical Nutritional Therapy	✓	✓	✓
Orthotics	✓	✓	✓
Oxygen and Respiratory Therapy Equipment	✓	✓	✓
Pharmacy (Please see below for categories of Pharmacy that are not included in TCOC calculations.) **1) Prescription Drugs, including but not limited to Hepatitis C Viral Drugs (HCV)** **2) Over-the-Counter Drugs** **3) Non-Drug Pharmacy Products**	✓	✓	✓
Physician (primary and specialty)	✓	✓	✓
Podiatry	✓	✓	✓
Preventive Pediatric Health Screening and Diagnostic Services		✓	
Prosthetic Services and Devices	✓	✓	✓
Radiology and Diagnostic Tests	✓	✓	✓
Remote Patient Monitoring	✓	✓	✓
School Based Health Center Services	✓	✓	
Therapy	✓	✓	✓

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
1) Physical **2) Occupational** **3) Speech and Hearing**			
Tobacco Cessation Services	✓	✓	✓
Transportation (emergent)	✓	✓	✓
Transportation (non-emergent, to out-of-state location)	✓		✓
Urgent Care Clinic Services	✓	✓	✓
Vaccine Counseling Services	✓	✓	✓
Vision Care (medical component)	✓	✓	✓
Wigs	✓	✓	✓

APPENDIX A

Exhibit 2: Services Not Included in TCOC Calculations

✓ Denotes a service not included in TCOC calculations

These services coordinated by the Contractor are not factored into TCOC calculations.

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Abortion	✓	✓	✓
Adult Dentures	✓	✓	✓
Adult Day Health	✓		
Adult Foster Care	✓		
Applied Behavioral Analysis for members under 21 years of age (ABA Services)	✓		
Chronic, Rehabilitation Hospital, or Nursing Facility Services, both beyond 100 days per Contract Year, consistent with MassHealth policy, and any stay of any duration in a Commonwealth-designated COVID-19 nursing facility	✓	✓	
Day Habilitation	✓		
Digital Therapy Products	✓	✓	✓
Preventative and Basic Dental Services	✓	✓	✓
Group Adult Foster Care	✓		
Isolation and Recovery Site Services	✓	✓	✓
Personal Care Attendant	✓		
Pharmacy –Non-HCV High Cost Drugs	✓	✓	✓
Private Duty Nursing/Continuous Skilled Nursing	✓	✓	
Residential Rehabilitation Services (Level 3.1)	✓	✓	✓
1. Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
2. Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
3. Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
4. Youth Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
5. Co-Occurring Enhanced Residential Rehabilitation Services (Level 3.1)	✓	✓	✓
Recovery Coaching	✓	✓	✓
Recovery Support Navigators	✓	✓	✓
Transitional Support Services (TSS) for Substance Use Disorders (Level 3)	✓	✓	✓
Transportation (non-emergent, to in-state location or location within 50 miles of the Massachusetts border)	✓		✓
Vision Care (non-medical component)	✓	✓	✓

Appendix A

Exhibit 3: Behavioral Health Services Included in TCOC Calculations

✓ Denotes a service included in TCOC Calculations

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
Inpatient Services			
1. Inpatient Mental Health Services	✓	✓	✓
2. Inpatient Substance Use Disorder Services (Level 4)	✓	✓	✓
3. Observation/Holding Beds	✓	✓	✓
4. Administratively Necessary Day (AND) Services	✓	✓	✓
Diversionary Services			
24-Hour Diversionary Services			
a. Community Crisis Stabilization	✓	✓	✓
b. Community-Based Acute Treatment for Children and Adolescents (CBAT)	✓	✓	
c. Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	✓	✓	✓
d. Clinical Support Services for Substance Use Disorders (Level 3.5)	✓	✓	✓
e. Transitional Care Unit (TCU)	✓	✓	
Non-24-Hour Diversionary Services			
a. Community Support Program (CSP) and Specialized CSP **1. CSP for Justice Involved** **2. CSP for Homeless Individuals** 3. **CSP – Tenancy Preservation Program**	✓	✓	✓
b. Partial Hospitalization (PHP)	✓	✓	✓
c. Psychiatric Day Treatment	✓	✓	✓
d. Structured Outpatient Addiction Program (SOAP)	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
e. Intensive Outpatient Program (IOP)	✓	✓	✓
f. Program of Assertive Community Treatment (PACT)	✓	✓	✓
Outpatient Services			
Standard Outpatient Services			
a. Family Consultation	✓	✓	✓
b. Case Consultation	✓	✓	✓
c. Diagnostic Evaluation	✓	✓	✓
d. Dialectical Behavioral Therapy (DBT)	✓	✓	✓
e. Psychiatric Consultation on an Inpatient Medical Unit	✓	✓	✓
f. Medication Visit	✓	✓	✓
g. Couples/Family Treatment	✓	✓	✓
h. Group Treatment	✓	✓	✓
i. Individual Treatment	✓	✓	✓
j. Inpatient-Outpatient Bridge Visit	✓	✓	✓
k. Assessment for Safe and Appropriate Placement (ASAP)	✓	✓	
l. Collateral Contact	✓	✓	
m. Acupuncture Treatment	✓	✓	✓
n. Opioid Treatment Services	✓	✓	✓
o. Ambulatory Withdrawal Management (Level 2WM)	✓	✓	✓
p. Psychological Testing	✓	✓	✓
q. Special Education Psychological Testing	✓	✓	
r. Early Intensive Behavioral Intervention (EIBI)	✓	✓	
s. Preventive Behavioral Health Services	✓	✓	
Intensive Home or Community-Based Services for Youth			
a. Family Support and Training	✓		

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
b. Intensive Care Coordination	✓		
c. In-Home Behavioral Services 1) Behavior Management Therapy 2) Behavior Management Monitoring	✓		
d. In-Home Therapy Services 1) Therapeutic Clinical Intervention 2) Ongoing Therapeutic Training and Support	✓	✓	
e. Therapeutic Mentoring Services	✓		
Crisis Services			
1. Adult Mobile Crisis Intervention (AMCI) Encounter	✓	✓	✓
2. Youth Mobile Crisis Intervention (YMCI)	✓	✓	
3. Emergency Department-based Crisis Intervention Mental Health Services 1) Crisis Evaluation 2) Crisis Stabilization Interventions 3) Discharge Planning and Care Coordination	✓	✓	✓
Other Behavioral Health Services			
1. Electro-Convulsive Therapy (ECT)	✓	✓	✓
2. Repetitive Transcranial Magnetic Stimulation (rTMS)	✓	✓	✓
3. Specialing	✓	✓	✓

APPENDIX A

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 included in the Contractor's TCOC.

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.

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. Non-covered laboratory services as specified in 130 CMR 401.411.

6. Services not otherwise covered by MassHealth, except as determined by EOHHS to be Medically Necessary for MassHealth Standard or MassHealth CommonHealth Enrollees under age 21. In accordance with EPSDT requirements, such services will be included in the Contractor's TCOC under the Contract.

Appendix B

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 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 **Section 2.10** 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 2.12** and **2.12.E** 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 2.4.E** of the Contract. The CP Quality Score shall be used in the determination of incentive payments made by the Contractor to each of its subcontracted CPs.

This Section of the Appendix describes the individual measures, and general methodology EOHHS will use to calculate the Contractor's scores (i.e., ACO Quality Score, ACO Health Equity Score, and CP Quality Score), as further specified by EOHHS.

2 Scoring Methodology for ACO Quality Score

The Contractor's Quality Score is based on the Contractor's performance across a set of benchmarks and improvement targets for individual measures that are grouped into three domains. EOHHS will weight and sum the Contractor's performance across domains to calculate one overall ACO Quality Score per performance year. For any measure where the Contractor does not meet minimum denominator requirements, as determined by EOHHS, then the measure's weight will be equally distributed to other measures within the same domain.

For ACOs serving primarily pediatric members (e.g., ≥ 75% of the ACO's Enrollees are ages 0-17 years), EOHHS shall replace adult focused measures (i.e., measures applicable to 18+ populations only) with measure(s) applicable to pediatric populations only ("pediatric replacement measures") as further specified by EOHHS. Quality Performance on these pediatric replacement measures will be scored as described above.

2.a List of Quality Measures for ACO Quality Score

Quality Measures include claims-based measures, clinical quality measures, and member experience surveys across the following three domains:

- Preventive and Pediatric Care
- Care Coordination / Care for Chronic & Acute Conditions
- Member Experience

See Exhibit 2 for the list of Quality Measures.

EXHIBIT 2 – ACO Quality Measures

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	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	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 Drug Abuse or Dependence (7 days)	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
		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

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004	2024
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 2.12.E** 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, 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 **Section 2.10.A** of the Contract).
        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 antidepressant medication treatment	Claims	NCQA	0105
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 **Sections 2.10.C and 2.12.E.** Community Partner Quality Scores will be applied to incentive payments to CP subcontractors as described in **Section 2.4.E.**

Appendix D: 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 2.4 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 F
ACO REPORTING REQUIREMENTS

This Appendix summarizes certain reporting requirements described in the Contract. This summary does not supersede contract language, nor does it capture all possible report requests as part of the Readiness Review. EOHHS may update these requirements from time to time. The Contractor shall submit corresponding Certification Checklists of all reports/submissions listed in **Appendix F** 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 F**, 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, Behavioral Health, 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-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)	Annual	OnBase
CM-17-A	**CM-17-A Enrollee Inquiries Summary** Inquiries and Grievances Summary: Enrollee Inquiries	Annual	OnBase
CM-17-B	**CM-17-B Enrollee Grievances Summary** Inquiries and Grievances Summary: Enrollee Grievances	Annual	OnBase
CM-17-F	**CM-17-F - Grievances Report (per 1,000 Enrollees)** Grievances Report (per 1,000 Enrollees)	Monthly	OnBase
CM-18	**[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	Annual	OnBase
CM-31	**CM-31 Notification of Federally Required Disclosures** Notification of Federally Required Disclosures (in accordance with Section 5.26.A)	Ad-Hoc	OnBase
CM-43-A	**CM-43-A Holiday Closures and Other Contractor Office Closures Annual** Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annual	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-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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-49	**CM-49 Written Disclosure of Identified Prohibited Affiliations** Written Disclosure of Identified Prohibited Affiliations	Ad-Hoc	OnBase
CM-50	**[RETIRED]**		
CM-57	**CM-57 Notification of changes to Provider Directory links on ACO's website** Notification of changes to Provider Directory links on ACO's website	Ad-Hoc	Secure Email
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annual	OnBase

C. 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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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

D. ACO Health Equity Reporting

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	To be determined.		

E. Operations Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
OP-04	**OP-04 Member Discrepancy Report** Member Discrepancy Report	Monthly	OnBase
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

F. 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-08	**PI-08 - Self-Reported Disclosures** Self-Reported Disclosures	Ad-Hoc	OnBase

G. Quality Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-01	**QR-01 QM/QI Program Description/Workplan** Written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor's QM/QI initiatives.	Annually	OnBase
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** Validation of Performance Measures	Annually	EQRO

APPENDIX G

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 2.4.E** of the Contract and in this **Appendix G**. 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 2.4.E.8**.

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 2.4.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 2.4.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 2.4.C.3** of the Contract and **Section 1.2** of this **Appendix G** 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 2.3.B.4** of the Contract. The CP shall utilize a Comprehensive Assessment tool of their choosing as set forth in **Section 2.3.B.4**. In addition to the requirements in **Section 2.3.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 2.3.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 2.3.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 2.3.B.3**, 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 2.3.B.5** of the Contract. The CP shall utilize a Care Plan template approved by the Contractor that meets the requirements of **Section 2.3.B.5** of the Contract. In addition to the requirements in **Section 2.3.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 2.4.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 2.4.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 2.3.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 TCOC Included Services and services not included in the TCOC calculations, as specified in **Appendix A**, 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 PCP referrals for TCOC Included Services and services not included in TCOC calculations. Such process shall include communications between the Parties about any prior authorization decisions (e.g., approval, modification or denial) made by EOHHS.

G. Support for Transitions of Care

In addition to the requirements of **Section 2.4.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 2.12** 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 G**.
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 2.4.E.9**, 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 G**;

      (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 2.4.E.11** 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 G**. 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 2.4.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 2.9.G.** 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 2.9.G.2** 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 G**;

        (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 G**; 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 G**;

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 I
TCOC BENCHMARKS

EXHIBIT 1
TCOC BENCHMARKS AND ADMINISTRATIVE PAYMENTS
Contract Year 1

Listed below are the Per Member Per Month (PMPM) TCOC Benchmarks and Administrative Payments and Primary Care Sub-Capitation Payments (together "PCACO Payments") for Contract Year 1 (April 1, 2023, through December 31, 2023), subject to state appropriation and all necessary federal approvals.

TCOC Benchmarks do not include EOHHS adjustments described in **Sections 4.5.D** of the Contract.

Exhibit 1.1: ACO TCOC Benchmarks (per member per month) effective April 1, 2023 – December 31, 2023

RC I Adult Effective April 1, 2023 – December 31, 2023	
REGION	**TCOC BENCHMARK**
Northern	**$554.04**
Greater Boston	**$575.69**
Southern	**$591.14**
Central	**$546.66**
Western	**$508.77**

RC I Child Effective April 1, 2023 – December 31, 2023	
REGION	**TCOC BENCHMARK**
Northern	**$237.65**
Greater Boston	**$252.69**
Southern	**$249.57**
Central	**$250.03**
Western	**$257.41**

RC II Adult Effective April 1, 2023 – December 31, 2023	
REGION	**TCOC BENCHMARK**
Northern	$1,979.36
Greater Boston	$2,126.41
Southern	$2,045.97
Central	$1,930.82
Western	$1,691.35

RC II Child Effective April 1, 2023 – December 31, 2023	
REGION	**TCOC BENCHMARK**
Northern	$1,248.19
Greater Boston	$1,263.78
Southern	$1,163.15
Central	$1,059.84
Western	$888.13

RC IX Effective April 1, 2023 – December 31, 2023	
REGION	**TCOC BENCHMARK**
Northern	$605.33
Greater Boston	$598.62
Southern	$673.24
Central	$634.54
Western	$603.48

RC X Effective April 1, 2023 – December 31, 2023	
REGION	**TCOC BENCHMARK**
Northern	**$2,007.26**
Greater Boston	**$2,131.85**
Southern	**$1,866.72**
Central	**$1,736.07**
Western	**$1,581.25**

Exhibit 1.2: PCACO Payments (per member per month) effective April 1, 2023 – December 31, 2023

Primary Care Sub-Capitation Payments Effective April 1, 2023 – December 31, 2023						
REGION	**RC I Adult**	**RC I Child**	**RC II Adult**	**RC II Child**	**RC IX**	**RC X**
Northern	**$25.41**	**$31.32**	**$38.78**	**$31.62**	**$25.41**	**$38.78**
Greater Boston	**$44.60**	**$53.62**	**$65.42**	**$49.57**	**$44.60**	**$65.42**
Southern	**$24.94**	**$32.01**	**$41.49**	**$31.67**	**$24.94**	**$41.49**
Central	**$22.62**	**$26.05**	**$35.79**	**$27.22**	**$22.62**	**$35.79**
Western	**$24.33**	**$30.48**	**$35.00**	**$32.63**	**$24.33**	**$35.00**

ACO Administrative Payments Effective April 1, 2023 – December 31, 2023						
REGION	**RC I Adult**	**RC I Child**	**RC II Adult**	**RC II Child**	**RC IX**	**RC X**
Northern	**$27.87**	**$21.30**	**$60.11**	**$59.97**	**$28.83**	**$59.84**
Greater Boston	**$28.13**	**$21.84**	**$63.29**	**$64.72**	**$28.75**	**$62.74**
Southern	**$28.67**	**$22.04**	**$60.53**	**$59.08**	**$30.47**	**$58.11**
Central	**$28.27**	**$21.82**	**$59.16**	**$54.35**	**$29.75**	**$55.18**
Western	**$27.16**	**$21.59**	**$53.03**	**$47.84**	**$28.64**	**$48.98**

EXHIBIT 2
STOP-LOSS ATTACHMENT POINT
Contract Year 1

The table below indicates the admission-level stop-loss attachment point as described in **Section 4.5.D.c** for the Contract Year.

Admission Level Stop-Loss Attachment Point
$150,000

EXHIBIT 3
MINIMUM SAVINGS AND LOSSES THRESHOLD SELECTION
Contract Year 1

The table below indicates the Contractor's selected minimum savings and losses threshold as described in **Section 4.5.C** for the Contract Year.

Minimum Savings and Losses Rate	**Minimum Savings and Losses Rate Selection** **✓= Selected; X = Not Selected**
1%	✓
2%	**X**

EXHIBIT 4
RISK TRACK SELECTION
Contract Year 1

The table below indicates the Contractor's selected Risk Track as described in **Section 4.5.C** for the Contract Year.

Risk Track	**Risk Track Selection** **✓= Selected; X = Not Selected**
Risk Track 1 – Full Accountability	✓
Risk Track 2 – Shared Accountability	**X**
Risk Track 3 – Narrow Accountability	**X**

EXHIBIT 5
RISK SHARING ARRANGEMENTS

Market-Wide Risk Sharing Arrangement ("Market Corridor")

1. Gain on the Market Corridor

If the Market Corridor expenditures, as determined by EOHHS in accordance with **Section 4.5.A**, are greater than or less than the Market Corridor revenue, as determined by EOHHS in accordance with **Section 4.5.A**, the Contractor and EOHHS shall share the resulting loss or gain as follows:

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%

TCOC Shared Savings/Shared Losses (Plan Corridor)

Risk Track 1 – Full Accountability

If the Contractor selects Risk Track 1 – Full Accountability as set forth in **Section 4.5**, the Contractor's Shared Savings payment or Shared Losses payment shall be as follows:

Savings	MassHealth Share	Contractor Share
Absolute value of savings less than or equal to 5% of the TCOC Benchmark	0%	100%
Absolute value of savings greater than 5% of the TCOC Benchmark	95%	5%

Losses	MassHealth Share	Contractor Share
Absolute value of losses with an absolute value less than or equal to 5% of TCOC Benchmark	0%	100%
Absolute value of losses with an absolute value greater than 5% of the TCOC Benchmark	95%	5%

Risk Track 2 – Shared Accountability

If the Contractor selects Risk Track 2 – Shared Accountability as set forth in in **Section 4.5**, the Contractor's Shared Savings payment or Shared Losses payment shall be as follows:

Savings	MassHealth Share	Contractor Share
Absolute value of savings less than or equal to 5% of the TCOC Benchmark	30%	70%
Absolute value of savings greater than 5% of the TCOC Benchmark	95%	5%

Losses	MassHealth Share	Contractor Share
Absolute value of losses with an absolute value less than or equal to 5% of TCOC Benchmark	30%	70%
Absolute value of losses with an absolute value greater than 5% of the TCOC Benchmark	95%	5%

Risk Track 3 – Narrow Accountability

If the Contractor selects Risk Track 3 – Narrow Accountability as set forth in **Section 4.5**, the Contractor's Shared Savings payment or Shared Losses payment shall be as follows:

Savings	MassHealth Share	Contractor Share
Absolute value of savings less than or equal to 3% of the TCOC Benchmark	40%	60%
Absolute value of savings greater than 3% and less than or equal to 5% of the TCOC Benchmark	65%	35%
Absolute value of savings with an absolute value greater than 5% of the TCOC Benchmark	95%	5%

Losses	MassHealth Share	Contractor Share
Absolute value of losses with an absolute value less than or equal to 3% of TCOC Benchmark	40%	60%
Absolute value of losses greater than 3% and less than or equal to 5% of the TCOC Benchmark	65%	35%
Absolute value of losses with an absolute value greater than 5% of the TCOC Benchmark	95%	5%

APPENDIX J

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 (April 1, 2023, 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 2.14.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 (per member per month)	PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT (per member per month)	TOTAL PCE SUB-CAPITATION RATE (see Section 2.14.A.1.h) (per member per month)
[redacted]	$ 18.94	$ 4.99	$ 23.93
[redacted]	$ 19.75	$ 4.05	$ 23.80
[redacted]	$ 16.33	$ 4.01	$ 20.34
[redacted]	$ 13.90	$ 4.12	$ 18.02
[redacted]	$ 25.94	$ 4.00	$ 29.94
[redacted]	$ 20.42	$ 12.90	$ 33.32
[redacted]	$ 56.03	$ 11.16	$ 67.19
[redacted]	$ 17.56	$ 4.11	$ 21.67
[redacted]	$ 21.54	$ 4.93	$ 26.47
[redacted]	$ 21.23	$ 12.73	$ 33.96
[redacted]	$ 17.30	$ 4.19	$ 21.49
[redacted]	$ 21.56	$ 4.33	$ 25.89
[redacted]	$ 20.43	$ 4.03	$ 24.46
[redacted]	$ 18.69	$ 4.04	$ 22.73
[redacted]	$ 19.18	$ 4.01	$ 23.19

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 (per member per month)	PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT (per member per month)	TOTAL PCE SUB-CAPITATION RATE (see Section 2.14.A.1.h) (per member per month)
[redacted]	$ 23.41	$ 12.90	$ 36.31
[redacted]	$ 20.08	$ 4.95	$ 25.03
[redacted]	$ 13.48	$ 4.28	$ 17.76
[redacted]	$ 16.28	$ 4.97	$ 21.25
[redacted]	$ 24.03	$ 4.06	$ 28.09
[redacted]	$ 16.34	$ 4.12	$ 20.46
[redacted]	$ 27.17	$ 12.89	$ 40.06
[redacted]	$ 12.25	$ 4.08	$ 16.33
[redacted]	$ 17.36	$ 4.15	$ 21.51
[redacted]	$ 17.80	$ 4.27	$ 22.07
[redacted]	$ 14.85	$ 4.05	$ 18.90
[redacted]	$ 10.81	$ 4.23	$ 15.04
[redacted]	$ 15.46	$ 4.08	$ 19.54
[redacted]	$ 25.97	$ 4.08	$ 30.05
[redacted]	$ 26.37	$ 4.92	$ 31.29
[redacted]	$ 21.42	$ 4.98	$ 26.40
[redacted]	$ 15.08	$ 4.03	$ 19.11
[redacted]	$ 16.33	$ 4.11	$ 20.44
[redacted]	$ 19.14	$ 4.05	$ 23.19
[redacted]	$ 14.71	$ 4.13	$ 18.84
[redacted]	$ 25.89	$ 4.96	$ 30.85
[redacted]	$ 22.21	$ 4.30	$ 26.51
[redacted]	$ 17.37	$ 4.01	$ 21.38
[redacted]	$ 18.91	$ 4.66	$ 23.57
[redacted]	$ 16.66	$ 4.17	$ 20.83
[redacted]	$ 16.23	$ 4.21	$ 20.44

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 (per member per month)	PCE SUB-CAPITATION RATE COMPONENT: TIER ENHANCED PAYMENT (per member per month)	TOTAL PCE SUB-CAPITATION RATE (see Section 2.14.A.1.h) (per member per month)
[redacted]	$ 17.48	$ 4.07	$ 21.55
[redacted]	$ 15.52	$ 4.00	$ 19.52
[redacted]	$ 29.82	$ 4.07	$ 33.89
[redacted]	$ 18.28	$ 4.02	$ 22.30
[redacted]	$ 59.34	$ 4.02	$ 63.36
[redacted]	$ 18.32	$ 4.14	$ 22.46
[redacted]	$ 22.65	$ 6.56	$ 29.21
[redacted]	$ 21.80	$ 4.09	$ 25.89
[redacted]	$ 17.36	$ 4.35	$ 21.71
[redacted]	$ 20.50	$ 4.93	$ 25.43
[redacted]	$ 9.00	$ 4.04	$ 13.04
[redacted]	$ 19.67	$ 4.03	$ 23.70
[redacted]	$ 15.11	$ 4.07	$ 19.18
[redacted]	$ 14.67	$ 4.21	$ 18.88
[redacted]	$ 16.05	$ 4.13	$ 20.18
[redacted]	$ 19.32	$ 4.02	$ 23.34
[redacted]	$ 16.94	$ 4.02	$ 20.96
[redacted]	$ 17.23	$ 4.26	$ 21.49
[redacted]	$ 13.68	$ 4.11	$ 17.79
[redacted]	$ 24.53	$ 4.05	$ 28.58
[redacted]	$ 23.26	$ 4.01	$ 27.27
[redacted]	$ 27.65	$ 4.02	$ 31.67