

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM



This form is jointly issued and published by the Executive Office for Administration and Finance (ANF), the Office of the Comptroller (CTR) and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. Any changes to the official printed language of this form shall be void. Additional non-conflicting terms may be added by Attachment. Contractors may not require any additional agreements, engagement letters, contract forms or other additional terms as part of this Contract without prior Department approval. Click on hyperlinks for definitions, instructions and legal requirements that are incorporated by reference into this Contract. An electronic copy of this form is available at www.mass.gov/osc under Guidance For Vendors - Forms or www.mass.gov/osd under OSD Forms.

CONTRACTOR LEGAL NAME: Massachusetts Behavioral Health Partnership (and d/b/a):		COMMONWEALTH DEPARTMENT NAME: Exec. Off. of Health and Human Services MMARS Department Code: EHS	
Legal Address: (W-9, W-4,T&C): 1000 Washington St., Ste. 310, Boston, MA 02118-5002		Business Mailing Address: One Ashburton Place, 11 th Floor, Boston, MA, 02108	
Contract Manager: Carol Kress		Billing Address (if different): 600 Washington Street, Boston, MA 02111	
E-Mail: Carol.kress@valueoptions.com		Contract Manager: Stephanie J. Brown	
Phone: 617-790-4144	Fax:	E-Mail: Stephanie.J.Brown@state.ma.us	
Contractor Vendor Code: VC6000182737		Phone: 617-573-1759	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: 11LCEHSPCCPLANBHPMSSRFR			

<p style="text-align: center;"><u>NEW CONTRACT</u></p> <p>PROCUREMENT OR EXCEPTION TYPE: (Check one option only)</p> <p><input type="checkbox"/> <u>Statewide Contract</u> (OSD or an OSD-designated Department)</p> <p><input type="checkbox"/> <u>Collective Purchase</u> (Attach OSD approval, scope, budget)</p> <p><input type="checkbox"/> <u>Department Procurement</u> (Includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation)</p> <p><input type="checkbox"/> <u>Emergency Contract</u> (Attach justification for emergency, scope, budget)</p> <p><input type="checkbox"/> <u>Contract Employee</u> (Attach Employment Status Form, scope, budget)</p> <p><input type="checkbox"/> <u>Legislative/Legal or Other:</u> (Attach authorizing language/justification, scope and budget)</p>	<p style="text-align: center;"><u>X CONTRACT AMENDMENT</u></p> <p>Enter Current Contract End Date <u>Prior</u> to Amendment: <u>1/31/2018</u></p> <p>Enter Amendment Amount: \$ <u>No Change</u> (or "no change")</p> <p>AMENDMENT TYPE: (Check one option only. Attach details of Amendment changes.)</p> <p><input checked="" type="checkbox"/> <u>Amendment to Scope or Budget</u> (Attach updated scope and budget)</p> <p><input type="checkbox"/> <u>Interim Contract</u> (Attach justification for Interim Contract and updated scope/budget)</p> <p><input type="checkbox"/> <u>Contract Employee</u> (Attach any updates to scope or budget)</p> <p><input type="checkbox"/> <u>Legislative/Legal or Other:</u> (Attach authorizing language/justification and updated scope and budget)</p>
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The following **COMMONWEALTH TERMS AND CONDITIONS (T&C)** has been executed, filed with CTR and is incorporated by reference into this Contract.

☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions For Human and Social Services

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 (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. Attached all supporting documentation and justifications.) Amendment 2 to the First Amended and Restated Contract is for the purposes of making programmatic and financial changes that include, but are not limited to: (1) Extending the term of the contract through December 31, 2018; (2) Adding language addresses the ACO rollout; (3) Inserting the MCPAP language drafted in collaboration with DMH; (4) Deleting and replacing Appendix A-1, Covered Services for Contract Year 2018. Appendix A-1 includes new SUD covered services; (5) Deleting and replacing Appendix G, Behavioral Health Performance Incentives for Contract Year 2018; and (6) Deleting and replacing Appendix H-1, Payment and Risk Sharing Provisions for Contract Year 2018..

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

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

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

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

CONTRACT END DATE: Contract performance shall terminate as of 12/31/2018, 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 makes all certifications required under the attached Contractor Certifications (incorporated by reference if not attached hereto) under the pains and penalties of perjury, 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 including the Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response, 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.

<p>AUTHORIZING SIGNATURE FOR THE CONTRACTOR:</p> <p>X: <u>Carol Kress</u> Date: <u>1/31/18</u> (Signature and Date Must Be Handwritten At Time of Signature)</p> <p>Print Name: Carol Kress Print Title: Vice President, Client Partnerships, MBHP</p>	<p>AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:</p> <p>X: _____ Date: _____ (Signature and Date Must Be Handwritten At Time of Signature)</p> <p>Print Name: Daniel Tsai Print Title: Assistant Secretary for MassHealth</p>
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CONTRACTOR LEGAL NAME: Massachusetts Behavioral Health Partnership (and d/b/a):		COMMONWEALTH DEPARTMENT NAME: Exec. Off. of Health and Human Services MMARS Department Code: EHS	
Legal Address: (W-9, W-4, T&C): 1000 Washington St., Ste. 310, Boston, MA 02118-5002		Business Mailing Address: One Ashburton Place, 11 th Floor, Boston, MA, 02108	
Contract Manager: Carol Kress		Billing Address (if different): 600 Washington Street, Boston, MA 02111	
E-Mail: Carol.kress@valueoptions.com		Contract Manager: Stephanie J. Brown	
Phone: 617-790-4144	Fax:	E-Mail: Stephanie.J.Brown@state.ma.us	
Contractor Vendor Code: VC6000182737		Phone: 617-573-1759	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: 11LCEHSPCCPLANBHPMSSRFR			

<p style="text-align: center;">NEW CONTRACT</p> <p>PROCUREMENT OR EXCEPTION TYPE: (Check one option only)</p> <p><input type="checkbox"/> Statewide Contract (OSD or an OSD-designated Department)</p> <p><input type="checkbox"/> Collective Purchase (Attach OSD approval, scope, budget)</p> <p><input type="checkbox"/> Department Procurement (includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation)</p> <p><input type="checkbox"/> Emergency Contract (Attach justification for emergency, scope, budget)</p> <p><input type="checkbox"/> Contract Employee (Attach Employment Status Form, scope, budget)</p> <p><input type="checkbox"/> Legislative/Legal or Other: (Attach authorizing language/justification, scope and budget)</p>	<p style="text-align: center;">CONTRACT AMENDMENT</p> <p>Enter Current Contract End Date <u>Prior</u> to Amendment: <u>1/31/2018</u></p> <p>Enter Amendment Amount: \$ <u>No Change</u> (or "no change")</p> <p>AMENDMENT TYPE: (Check one option only. Attach details of Amendment changes.)</p> <p><input checked="" type="checkbox"/> Amendment to Scope or Budget (Attach updated scope and budget)</p> <p><input type="checkbox"/> Interim Contract (Attach justification for Interim Contract and updated scope/budget)</p> <p><input type="checkbox"/> Contract Employee (Attach any updates to scope or budget)</p> <p><input type="checkbox"/> Legislative/Legal or Other: (Attach authorizing language/justification and updated scope and budget)</p>
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The following **COMMONWEALTH TERMS AND CONDITIONS** (T&C) has been executed, filed with CTR and is incorporated by reference into this Contract.

☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions For Human and Social Services

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 ([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. Attached all supporting documentation and justifications.) **Amendment 2** to the First Amended and Restated Contract is for the purposes of making programmatic and financial changes that include, but are not limited to: (1) Extending the term of the contract through **December 31, 2018**; (2) Adding language addresses the ACO rollout; (3) Inserting the MCPAP language drafted in collaboration with DMH; (4) Deleting and replacing Appendix A-1, Covered Services for Contract Year 2018. Appendix A-1 includes new SUD covered services; (5) Deleting and replacing Appendix G, Behavioral Health Performance Incentives for Contract Year 2018; and (6) Deleting and replacing Appendix H-1, Payment and Risk Sharing Provisions for Contract Year 2018.

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

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

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

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

CONTRACT END DATE: Contract performance shall terminate as of **12/31/2018**, 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 makes all certifications required under the attached [Contractor Certifications](#) (incorporated by reference if not attached hereto) under the pains and penalties of perjury, 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 including the [Instructions and Contractor Certifications](#), the Request for Response (RFR) or other solicitation, the Contractor's Response, 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: _____ Date: _____ (Signature and Date Must Be Handwritten At Time of Signature) Print Name: <u>Carol Kress</u> Print Title: <u>Vice President, Client Partnerships, MBHP</u>	AUTHORIZING SIGNATURE FOR THE COMMONWEALTH: X: _____ Date: <u>1/31/18</u> (Signature and Date Must Be Handwritten At Time of Signature) Print Name: <u>Daniel Tsai</u> Print Title: <u>Assistant Secretary for MassHealth</u>
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COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM



INSTRUCTIONS AND CONTRACTOR CERTIFICATIONS

The following instructions and terms are incorporated by reference and apply to this Standard Contract Form. Text that appears underlined indicates a "hyperlink" to an Internet or bookmarked site and are unofficial versions of these documents and Departments and Contractors should consult with their legal counsel to ensure compliance with all legal requirements. Using the Web Toolbar will make navigation between the form and the hyperlinks easier. Please note that not all applicable laws have been cited.

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

Contractor Legal Address: Enter the Legal Address of the Contractor as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) and the applicable Commonwealth Terms and Conditions, which must match the legal address on the 10991 table in MMARS (or the Legal Address in HR/CMS for Contract Employee).

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

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

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

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

COMMONWEALTH DEPARTMENT NAME: Enter the full Department name with the authority to obligate funds encumbered for the Contract.

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

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

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

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

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

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

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

NEW CONTRACTS (left side of Form):

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

PROCUREMENT OR EXCEPTION TYPE: Check the appropriate type of procurement or exception for this Contract. Only one option can be selected. See State Finance Law and General Requirements, Acquisition Policy and Fixed Assets, the Commodities and Services Policy and the Procurement Information Center (Department Contract Guidance) for details.

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

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

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

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

Contract Employee: Check this option when the Department requires the performance of an Individual Contractor, and when the planned Contract performance with an Individual has been classified using the Employment Status Form (prior to the Contractor's selection) as work of a Contract Employee and not that of an Independent Contractor.

Legislative/Legal or Other: Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Supporting documentation must be attached to explain and justify the exemption.

CONTRACT AMENDMENT (Right Side of Form)

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

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

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

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

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

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

Legislative/Legal or Other: Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Attach supporting documentation to explain and justify the exemption and whether Contractor selection has been publicly posted.

COMMONWEALTH TERMS AND CONDITIONS

Identify which Commonwealth Terms and Conditions the Contractor has executed and is incorporated by reference into this Contract. This Form is signed only once and recorded on the Vendor Customer File (VCUST). See Vendor File and W-9s Policy.

COMPENSATION

COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM



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

PAYMENTS AND PROMPT PAY DISCOUNTS

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

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE

Enter a brief description of the Contract performance, project name and/or other identifying information for the Contract to specifically identify the Contract performance, match the Contract with attachments, determine the appropriate expenditure code (as listed in the [Expenditure Classification Handbook](#)) or to identify or clarify important information related to the Contract such as the Fiscal Year(s) of performance (ex. "FY2012" or "FY2012-14"). Identify settlements or other exceptions and attach more detailed justification and supporting documents. Enter "Multi-Department Use" if other Departments can access procurement. For Amendments, identify the purpose and what items are being amended. Merely stating "see attached" or referencing attachments without a narrative description of performance is insufficient.

ANTICIPATED START DATE

The Department and Contractor must certify WHEN obligations under this Contract/Amendment may be incurred. Option 1 is the default option when performance may begin as of the [Effective Date](#) (latest signature date and any required approvals). If the parties want a new Contract or renewal to begin as of the upcoming fiscal year then list the fiscal year(s) (ex. "FY2012" or "FY2012-14") in the Brief Description section. Performance starts and encumbrances reflect the default [Effective Date](#) (if no FY is listed) or the later FY start date (if a FY is listed). Use Option 2 only when the Contract will be signed well in advance of the start date and identify a specific future start date. Do not use Option 2 for a fiscal year start unless it is certain that the Contract will be signed prior to fiscal year. Option 3 is used in lieu of the [Settlement and Release Form](#) when the Contract/Amendment is signed late, and obligations have already been incurred by the Contractor prior to the [Effective Date](#) for which the Department has either requested, accepted or deemed legally eligible for reimbursement, and the Contract includes supporting documents justifying the performance or proof of eligibility, and approximate costs. Any obligations incurred outside the scope of the [Effective Date](#) under any Option listed, even if the incorrect Option is selected, shall be automatically deemed a settlement included under the terms of the Contract and upon payment to the Contractor will release the Commonwealth from further obligations for the identified performance. All settlement payments require justification and must be under same encumbrance and object codes as the Contract payments. Performance dates are subject to [G.L. c.4, §.9](#).

CONTRACT END DATE

The Department must enter the date that Contract performance will terminate. **If the Contract is being amended and the Contract End Date is not changing, this date must be re-entered again here.** A Contract must be signed for at least the initial duration but not longer than the period of procurement listed in the RFR, or other solicitation document (if applicable). No new performance is allowable beyond the end date without an amendment, but the Department may allow a Contractor to complete minimal close out performance obligations if substantial performance has been made prior to the termination date of the Contract and prior to the end of the fiscal year in which payments are

appropriated, provided that any close out performance is subject to appropriation and funding limits under state finance law, and CTR may adjust encumbrances and payments in the state accounting system to enable final close out payments. Performance dates are subject to [G.L. c.4, §.9](#).

CERTIFICATIONS AND EXECUTION

See [Department Head Signature Authorization Policy](#) and the [Contractor Authorized Signatory Listing](#) for policies on Contractor and Department signatures.

Authorizing Signature for Contractor/Date: The Authorized Contractor Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under ["Anticipated Contract Start Date"](#). Acceptance of payment by the Contractor shall waive any right of the Contractor to claim the Contract/Amendment is not valid and the Contractor may not void the Contract. **Rubber stamps, typed or other images are not acceptable.** Proof of Contractor signature authorization on a [Contractor Authorized Signatory Listing](#) may be required by the Department if not already on file.

Contractor Name /Title: The Contractor Authorized Signatory's name and title must appear legibly as it appears on the [Contractor Authorized Signatory Listing](#).

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

Department Name /Title: Enter the Authorized Signatory's name and title legibly.

CONTRACTOR CERTIFICATIONS AND LEGAL REFERENCES

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

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

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

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

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

Public Records and Access The Contractor shall provide full access to records related to performance and compliance to the Department and officials listed under [Executive Order 195 and G.L. c. 11, s.12](#) seven (7) years beginning on the first day after the final payment under this Contract or such longer period necessary for the resolution of any litigation, claim, negotiation, audit or other inquiry involving this Contract. Access to view Contractor records related to any breach or allegation of fraud, waste and/or abuse may not be denied and Contractor can not claim confidentiality or trade secret protections solely for viewing but not retaining documents. Routine Contract performance compliance reports or documents related to any alleged breach or allegation of non-compliance, fraud, waste, abuse or collusion may be provided electronically and shall be provided at Contractor's own expense. Reasonable costs for copies of non-routine Contract related records shall not exceed the rates for public records under [950 C.M.R. 32.00](#).

Debarment. The Contractor certifies that neither it nor any of its subcontractors are currently debarred or suspended by the federal or state government under any law or

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regulation including, [Executive Order 147](#); [G.L. c. 29, s. 29F](#); [G.L. c. 30, § 39R](#); [G.L. c. 149, § 27C](#); [G.L. c. 149, § 44C](#); [G.L. c. 149, § 148B](#) and [G.L. c. 152, s. 25C](#).

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

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

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

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

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

Bankruptcy, Judgments, Potential Structural Changes, Pending Legal Matters and Conflicts. The Contractor certifies it has not been in bankruptcy and/or receivership within the last three calendar years, and the Contractor certifies that it will immediately notify the Department in writing at **least 45 days prior** to filing for bankruptcy and/or receivership, any potential structural change in its organization, or if there is **any risk** to the solvency of the Contractor that may impact the Contractor's ability to timely fulfill the terms of this Contract or Amendment. The Contractor certifies that at any time during the period of the Contract the Contractor is required to affirmatively disclose in writing to the Department Contract Manager the details of any judgment, criminal conviction, investigation or litigation pending against the Contractor or any of its officers, directors, employees, agents, or subcontractors, including any potential conflicts of interest of which the Contractor has knowledge, or learns of during the Contract term. Law firms or Attorneys providing legal services are required to identify any potential conflict with representation of any Department client in accordance with Massachusetts Board of Bar Overseers (BBO) rules.

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

Protection of Personal Data and Information. The Contractor certifies that all steps will be taken to ensure the security and confidentiality of all Commonwealth data for which the Contractor becomes a holder, either as part of performance or inadvertently during performance, with special attention to restricting access, use and disbursement of personal data and information under [G.L. c. 93H](#) and [c. 66A](#) and [Executive Order 504](#). The Contractor is required to comply with [G.L. c. 93I](#) for the proper disposal of all paper and electronic media, backups or systems containing personal data and information, provided further that the Contractor is required to ensure that any personal data or information

transmitted electronically or through a portable device be properly encrypted using (at a minimum) [Information Technology Division \(ITD\) Protection of Sensitive Information](#), provided further that any Contractor having access to credit card or banking information of Commonwealth customers certifies that the Contractor is PCI compliant in accordance with the [Payment Card Industry Council Standards](#) and shall provide confirmation compliance during the Contract, provide further that the Contractor shall immediately notify the Department in the event of any security breach including the unauthorized access, disbursement, use or disposal of personal data or information, and in the event of a security breach, the Contractor shall cooperate fully with the Commonwealth and provide access to any information necessary for the Commonwealth to respond to the security breach and shall be fully responsible for any damages associated with the Contractor's breach including but not limited to [G.L. c. 214, s. 3B](#).

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

Employer Requirements. Contractors that are employers certify compliance with applicable state and [federal employment laws](#) or regulations, including but not limited to [G.L. c. 5, s. 1](#) (Prevailing Wages for Printing and Distribution of Public Documents); [G.L. c. 7, s. 22](#) (Prevailing Wages for Contracts for Meat Products and Clothing and Apparel); [minimum wages and prevailing wage programs and payments](#); [unemployment insurance](#) and contributions; [workers' compensation and insurance](#), [child labor laws](#), [AGO fair labor practices](#); [G.L. c. 149](#) (Labor and Industries); [G.L. c. 150A](#) (Labor Relations); [G.L. c. 151](#) and [455 CMR 2.00](#) (Minimum Fair Wages); [G.L. c. 151A](#) (Employment and Training); [G.L. c. 151B](#) (Unlawful Discrimination); [G.L. c. 151E](#) (Business Discrimination); [G.L. c. 152](#) (Workers' Compensation); [G.L. c. 153](#) (Liability for Injuries); [29 USC c. 8](#) (Federal Fair Labor Standards); [29 USC c. 28](#) and the [Federal Family and Medical Leave Act](#).

Federal And State Laws And Regulations Prohibiting Discrimination including but not limited to the [Federal Equal Employment Opportunity \(EEO\) Laws](#) the [Americans with Disabilities Act](#); [42 U.S.C. Sec. 12,101, et seq.](#), the [Rehabilitation Act](#), [29 USC c. 16 s. 794](#); [29 USC c. 16 s. 701](#); [29 USC c. 14, 623](#); the [42 USC c. 45](#); (Federal Fair Housing Act); [G.L. c. 151B](#) (Unlawful Discrimination); [G.L. c. 151E](#) (Business Discrimination); the Public Accommodations Law [G.L. c. 272, s. 92A](#); [G.L. c. 272, s. 98](#) and [98A](#), [Massachusetts Constitution Article CXIV](#) and [G.L. c. 93, s. 103](#); [47 USC c. 5, sc. II, Part II, s. 255](#) (Telecommunication Act); Chapter 149, [Section 105D](#), [G.L. c. 151C](#), [G.L. c. 272, Section 92A, Section 98](#) and [Section 98A](#), and [G.L. c. 111, Section 199A](#), and [Massachusetts Disability-Based Non-Discrimination Standards For Executive Branch Entities](#), and related Standards and Guidance, authorized under Massachusetts Executive Order or any disability-based protection arising from state or federal law or precedent. See also [MCAD](#) and [MCAD links and Resources](#).

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

Limitation of Liability for Information Technology Contracts (and other Contracts as Authorized). The [Information Technology Mandatory Specifications](#) and the [IT Acquisition Accessibility Contract Language](#) are incorporated by reference into Information Technology Contracts. The following language will apply to Information Technology contracts in the U01, U02, U03, U04, U05, U06, U07, U08, U09, U10, U75, U98 object codes in the [Expenditure Classification Handbook](#) or other Contracts as approved by CTR or OSD. Pursuant to Section 11. Indemnification of the Commonwealth Terms and Conditions, the term "other damages" shall include, but shall not be limited to, the reasonable costs the Commonwealth incurs to repair, return, replace or seek cover (purchase of comparable substitute commodities and services) under a Contract. "Other damages" shall not include damages to the Commonwealth as a result of third party claims, provided, however, that the foregoing in no way limits the Commonwealth's right of recovery for personal injury or property damages or patent and copyright infringement under Section 11 nor the Commonwealth's ability to join the contractor as a third party defendant. Further, the term "other damages" shall not include, and in no event shall the contractor be liable for, damages for the Commonwealth's use of contractor provided products or services, loss of Commonwealth records, or data (or other intangible property), loss of use of equipment, lost revenue, lost savings or lost profits of the Commonwealth. In no event shall "other damages" exceed the greater of \$100,000, or two times the value of the product or service (as defined in the Contract scope of work) that is the subject of the claim. Section 11 sets forth the contractor's entire liability under a Contract. Nothing in this section shall limit the Commonwealth's ability to negotiate higher limitations of liability in a particular Contract, provided that any such limitation must specifically reference Section 11 of the Commonwealth Terms and Conditions. In the event the limitation of liability conflicts with accounting standards which mandate that there can be no cap of damages, the limitation shall be considered waived for that audit engagement. These terms may be applied to other Contracts only with prior written confirmation from the Operational Services Division or the Office of the Comptroller. The terms in this Clarification may not be modified.

Northern Ireland Certification. Pursuant to [G.L. c. 7 s. 22C](#) for state agencies, state authorities, the House of Representatives or the state Senate, by signing this Contract the

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Contractor certifies that it does not employ ten or more employees in an office or other facility in Northern Ireland and if the Contractor employs ten or more employees in an office or other facility located in Northern Ireland the Contractor certifies that it does not discriminate in employment, compensation, or the terms, conditions and privileges of employment on account of religious or political belief; and it promotes religious tolerance within the work place, and the eradication of any manifestations of religious and other illegal discrimination; and the Contractor is not engaged in the manufacture, distribution or sale of firearms, munitions, including rubber or plastic bullets, tear gas, armored vehicles or military aircraft for use or deployment in any activity in Northern Ireland.

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

Consultant Contractor Certifications (For Consultant Contracts "HH" and "NN" and "U05" object codes subject to [G.L. Chapter 29, s. 29A](#)). Contractors must make required disclosures as part of the RFR Response or using the [Consultant Contractor Mandatory Submission Form](#).

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

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

EXECUTIVE ORDERS

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

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

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

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

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

Executive Order 504. [Regarding the Security and Confidentiality of Personal Information.](#) For all Contracts involving the Contractor's access to personal information, as defined in [G.L. c. 93H](#), and personal data, as defined in [G.L. c. 66A](#), owned or controlled by Executive Department agencies, or access to agency systems containing such information or data (herein collectively "personal information"), Contractor certifies under the pains and

penalties of perjury that the Contractor (1) has read Commonwealth of Massachusetts Executive Order 504 and agrees to protect any and all personal information; and (2) has reviewed all of the Commonwealth [Information Technology Division's Security Policies](#). Notwithstanding any contractual provision to the contrary, in connection with the Contractor's performance under this Contract, for all state agencies in the Executive Department, including all executive offices, boards, commissions, agencies, departments, divisions, councils, bureaus, and offices, now existing and hereafter established, the Contractor shall: (1) obtain a copy, review, and comply with the contracting agency's Information Security Program (ISP) and any pertinent security guidelines, standards, and policies; (2) comply with all of the Commonwealth of Massachusetts Information Technology Division's "[Security Policies](#)"; (3) communicate and enforce the contracting agency's ISP and such Security Policies against all employees (whether such employees are direct or contracted) and subcontractors; (4) implement and maintain any other reasonable appropriate security procedures and practices necessary to protect personal information to which the Contractor is given access by the contracting agency from the unauthorized access, destruction, use, modification, disclosure or loss; (5) be responsible for the full or partial breach of any of these terms by its employees (whether such employees are direct or contracted) or subcontractors during or after the term of this Contract, and any breach of these terms may be regarded as a material breach of this Contract; (6) in the event of any unauthorized access, destruction, use, modification, disclosure or loss of the personal information (collectively referred to as the "unauthorized use"): (a) immediately notify the contracting agency if the Contractor becomes aware of the unauthorized use; (b) provide full cooperation and access to information necessary for the contracting agency to determine the scope of the unauthorized use; and (c) provide full cooperation and access to information necessary for the contracting agency and the Contractor to fulfill any notification requirements. Breach of these terms may be regarded as a material breach of this Contract, such that the Commonwealth may exercise any and all contractual rights and remedies, including without limitation indemnification under Section 11 of the [Commonwealth's Terms and Conditions](#), withholding of payments, Contract suspension, or termination. In addition, the Contractor may be subject to applicable statutory or regulatory penalties, including and without limitation, those imposed pursuant to G.L. c. 93H and under [G.L. c. 214, § 3B](#) for violations under M.G.L. c. 66A.

Executive Orders 523, 524 and 526. Executive Order 526 (Order Regarding Non-Discrimination, Diversity, Equal Opportunity and Affirmative Action which supersedes Executive Order 478). Executive Order 524 (Establishing the Massachusetts Supplier Diversity Program which supersedes Executive Order 390). Executive Order 523 (Establishing the Massachusetts Small Business Purchasing Program.) All programs, activities, and services provided, performed, licensed, chartered, funded, regulated, or contracted for by the state shall be conducted without unlawful discrimination based on race, color, age, gender, ethnicity, sexual orientation, gender identity or expression, religion, creed, ancestry, national origin, disability, veteran's status (including Vietnam-era veterans), or background. The Contractor and any subcontractors may not engage in discriminatory employment practices; and the Contractor certifies compliance with applicable federal and state laws, rules, and regulations governing fair labor and employment practices; and the Contractor commits to purchase supplies and services from certified minority or women-owned businesses, small businesses, or businesses owned by socially or economically disadvantaged persons or persons with disabilities. These provisions shall be enforced through the contracting agency, OSD, and/or the Massachusetts Commission Against Discrimination. Any breach shall be regarded as a material breach of the contract that may subject the contractor to appropriate sanctions.

AMENDMENT #2
to the
FIRST AMENDED AND RESTATED CONTRACT FOR
THE MASSHEALTH PCC PLAN'S COMPREHENSIVE BEHAVIORAL HEALTH
PROGRAM AND MANAGEMENT SUPPORT SERVICES, AND BEHAVIORAL
HEALTH SPECIALTY PROGRAMS CONTRACT

between

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID
1 ASHBURTON PLACE
BOSTON, MA 02108
and

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP
1000 WASHINGTON STREET
BOSTON, MA 02118

WHEREAS, The Massachusetts Executive Office of Health and Human Services (referred throughout the Contract as either "EOHHS" or "MassHealth") and the Massachusetts Behavioral Health Partnership ("Contractor") entered into a First Amended and Restated Contract, effective September 1, 2017, to provide innovative, cost-effective, high quality care management services, network management services, quality management activities and comprehensive Behavioral Health services for certain MassHealth Members, including but not limited to Care Management Program for individual Enrollees with complex medical and/or behavioral health conditions, through a program known as the MassHealth PCC Plan's Comprehensive Behavioral Health Program or Management Support Services, and Behavioral Health Specialty Programs ("BHP MSS Contract" or "Contract"); and **WHEREAS**, in accordance with **Section 13.3** of the Contract, EOHHS and the Contractor desire to further amend their agreement effective upon execution of this Amendment, in accordance with the rates, terms and conditions set forth herein; and

WHEREAS, EOHHS and the Contractor amended the First Amended and Restated Contract on December 29, 2017 (Amendment #1);

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

NOW, THEREFORE, in consideration of the mutual undertakings, EOHHS and the Contractor agree to amend the BHP MSS Contract as follows:

SECTION 1. DEFINITION AND ACRONYMS

- 1. Section 1.1** is hereby amended by inserting alphabetically the following definitions:-

“Contract Year 2018 – (“CY2018”) the period from January 1, 2018, to December 31, 2018. Contract Year 2018 includes the following periods:

- **Contract Period CY18A – (“CY18A”) the period from January 1, 2018, through February 28, 2018.**
- **Contract Period CY18B – (“CY18B”) the period from March 1, 2018, through December 31, 2018.**
- **Contract Period CY18MFP – (“CY18MFP”) the period from January 1, 2018, through March 31, 2018.**

Designated ED – A hospital with an ED to which an ESP has contracted specific ESP services as set forth in Appendix A-3.

Primary Care Accountable Care Organization (Primary Care ACO) – an entity contracted with EOHHS to be a Primary Care ACO.

Therapeutic Milieu – A setting including but not limited to a partial hospital program, psychiatric day treatment program, or CBAT, where behavioral health services are provided.”

- 2. Section 1.1 is hereby amended by deleting the following definitions in their entirety and replacing them with the following:-**

“Contract Year – except for Contract Year One, Contract Year 6A, and Contract Year 2018, the 12-month period beginning January 1 of each year.

Covered Individuals – MassHealth Members who are eligible to receive Behavioral Health Covered Services under BHP, including PCC Plan Enrollees, Members enrolled in a Primary Care ACO, MFP Waiver Participants, Children in the Care and/or Custody of the Commonwealth, and Children in MassHealth Standard or CommonHealth with other insurance.”

- 3. Section 1.2 is hereby amended by inserting alphabetically the following acronyms:-**

“ASAM – American Society for Addiction Medicine

DDCAT – Dual Diagnosis Capability in Addiction Treatment”

SECTION 2. GENERAL ADMINISTRATIVE REQUIREMENTS

- 1. Section 2.3. is hereby amended by adding the following as Section 2.3.H:-**

“H. Substance Use Disorder Services

1. Beginning March 1, 2018 or when otherwise directed by EOHHS, the Contractor shall provide Residential Rehabilitative Services, Recovery Support Navigator services, and Recovery Coach services to all Covered Individuals.
2. The Contractor shall provide Enhanced Residential Rehabilitative Services for Dually Diagnosed, Clinically Managed Population-Specific High Intensity Residential Services, and Transitional Support Services to all Covered Individuals when directed by EOHHS.”

SECTION 3. BEHAVIORAL HEALTH NETWORK RESPONSIBILITIES

1. **Section 3.1.A.1** is hereby amended by adding at the end therein the following subsection:-

“h. Effective care transitions and care continuity for Covered Individuals.”
2. **Section 3.1.B.6** is hereby amended by adding at the end therein the following subsection:-

“h. Substance use disorder”.
3. **Section 3.1.B.22** is hereby amended by striking it in its entirety and replacing it with the following: -

“22. The Contractor shall, unless otherwise directed by EOHHS, work collaboratively with EOHHS and with MassHealth-contracted plans to implement a unified Network Management strategy for utilization management, network provider requirements and other strategies as directed by EOHHS in the management of the network of Substance Use Disorder Level 3.1 and 3.3 service providers, including Residential Rehabilitation Services, and Enhanced Residential Services for Covered Individuals with high acuity and complexity as specified by EOHHS. In implementing a unified Network management strategy, the Contractor shall, as further specified by EOHHS:

 - a. Communicate, support, and provide technical assistance to the existing network of Level 3.1 providers contracted with the Department of Public Health (DPH) as necessary to credential and contract with those providers;
 - b. Develop communication, support, and technical assistance to the network of Level 3.3 service providers as it is developed and contracted with DPH as necessary to credential and contract with those providers;
 - c. Develop performance specifications and medical necessity criteria for Level 3.1 and 3.3 services;
 - d. Establish rates of reimbursement for Level 3.1 and 3.3 services; and

- e. Perform any additional activities, as directed by EOHHS or DPH, necessary to credential and contract with Level 3.1 and 3.3 providers that are not currently contracted with DPH but that are otherwise willing and qualified to provide Level 3.1 and 3.3 services to Covered Individuals.”
- 4. **Section 3.1.D** is hereby amended by adding at the end therein the following subsection:-
 - “5. The Contractor shall require the use of any standardized clinical assessment tools by substance use disorder treatment providers as directed by EOHHS.”
- 5. **Section 3.1.F.** is hereby amended by adding at the end therein the following subsection:-
 - “6. Ensure that access to out-of-network providers, in all cases described above, is permitted in a timely fashion and that there are no disruptions in treatment and/or access to medications due to negotiations around out-of-network providers.”
- 6. **Section 3.2.B.1** is hereby amended by adding at the end therein the following subsection:-
 - “e. Access and retention on medication for addiction treatment (MAT).”
- 7. **Section 3.2.B.2.c.** is hereby amended by deleting it in its entirety and replacing it with the following:-
 - “c. BSAS-funded programs such as Recovery Support Centers and Access to Recovery;”
- 8. **Section 3.4.A.5.d** hereby amended by deleting it in its entirety and replacing it with the following subsection:-
 - “d. authorizing within 24 hours Medically Necessary BH Covered Services following a Crisis Assessment and Intervention.”
- 9. **Section 3.4.B.6** is hereby amended by deleting it in its entirety and replacing it with the following subsection:-
 - “6. Encounter Forms

The Contractor shall:
 - a. Create and implement an EOHHS approved electronic ESP Encounter form to report on ESP Services described in **Appendix A-1**;
 - b. Require ESPs to complete and submit the electronic EOHHS-approved ESP Encounter form for each individual they serve;

- c. Work with EOHHS to transfer the records from the existing Encounter database, which includes the information contained in the ESP Encounter forms;
- d. Work with EOHHS to develop ESP reporting metrics consistent with the ESP Encounter data; and
- e. Develop reporting procedures, approved by EOHHS, to include but not limited to the following:-
 - 1) Monthly ESP Dashboard;
 - 2) Designated ED performance including data elements consistent with the ESP Providers;
 - 3) Monthly network management meeting list; and
 - 4) Standard process for reporting quality issues to EOHHS, including notification of any ESP provider or Designated ED on a corrective action.”

10. Section 3.4.B is hereby amended by adding at the end therein the following subsection:

- “13. The Contractor shall establish policies and procedures for Designated ED and ensure that the Designated EDs provide all ESP Services as set forth in **Appendix A-1**, consistent with the Contractor’s performance specifications.”

11. Section 3.5.E.14 is hereby amended by deleting it in its entirety and replacing it with the following:-

- “14. In collaboration with and as further directed by EOHHS, develop a process to monitor the quality of services using tools such as the MA DRM or another tool approved by EOHHS to evaluate the adequacy of medical record keeping for both ICC and In-Home Therapy Services (IHT). The Contractor shall apply the approved quality-assessing tool at least annually on a mix of ICC and IHT services provided across all of the Contractor’s regions. Unless otherwise directed by EOHHS, the Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Covered Individuals who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 10 Covered Individuals medical files per region per Contract Year.”

12. Section 3 is hereby amended by adding among therein the following new **Section 3.8** and renumbering the subsequent subsections accordingly:-

“Section 3.8 Collaboration with the Primary Care Accountable Care Organizations (Primary Care ACOs)

The Contractor shall collaborate with the Primary Care ACOs. Collaboration shall include but not be limited to:

- a. Implementation of the Primary Care ACO contracts;
- b. Integrated care management;
- c. Quality management;
- d. Reporting;
- e. Network development and management; and
- f. Other tasks as directed by EOHHS.”

SECTION 4. CLINICAL SERVICES AND UTILIZATION MANAGEMENT

1. **Section 4.4.A.4.b.3** is hereby amended by striking it in its entirety and replacing it with the following:-

“3) Educational supports to:

- a) The ICMP program;
- b) Network Providers and PCCs;
- c) Pediatric Behavioral Health Medication Initiative (PBHMI);
- d) The controlled substances management program; and
- e) Any other initiatives currently being worked on.”

2. **Section 4.4.A.5** is hereby amended by striking it in its entirety and replacing it with the following:-

“5. Ensure that sufficient pharmacist and/or clinical staff with an understanding of medication(s) as it relates to the project are available to fulfill the pharmacy requirements of the Contract.

- a. Provide to EOHHS for approval a staffing plan prior to the beginning of each Contract Year, including clinical and data analysis that ensures the clinical integrity of the pharmacy deliverables.
- b. The Contractor’s pharmacy director, as identified to EOHHS, shall have access to pharmacy data through POPS and the POPS data query tool known as “Business Objects” to support these efforts. If the Contractor supplies a level of clinical oversight for the use of the data that is approved by MassHealth, MassHealth may consider granting additional Contractor staff access to this tool on a case-by-case basis.”

3. **Section 4.5** is hereby amended by striking it in its entirety and replacing it with the following:-

“Section 4.5 Massachusetts Child Psychiatry Access Program

The Massachusetts Child Psychiatry Access Program (MCPAP) consists of two psychiatric consultation programs. The first program, MCPAP consists of children’s behavioral health consultation teams throughout the state to help pediatric Primary Care Practitioners (PCPs) manage the behavioral health needs of their patients.. Through consultation and education, MCPAP improves PCP’s competencies in screening, identification, and assessment, treating mild to moderate cases of behavioral health disorders, and in making effective referrals for patients who need community-based specialty services. The second program, MCPAP for Moms, consists of behavioral health consultation teams that provide behavioral health consultation for obstetric, pediatric, adult primary care and psychiatric providers to effectively prevent, identify, and manage depression and other mental health concerns in pregnant and postpartum women up to one year after delivery.

The Contractor shall:

- A. Maintain a Massachusetts Child Psychiatric Access Program (MCPAP) Unit to manage the Massachusetts Child Psychiatric Access Program, and allocate sufficient medical leadership and program administration resources to assure that the goals of the program are met and quality is maintained.
- B. Maintain a network of MCPAP providers to provide consultation to pediatric Primary Care Practitioners (PCPs), including Primary Care Clinicians (PCCs), treating pediatric Members who may need Behavioral Health services and a network of MCPAP for Mom providers to provide consultation to obstetric, pediatric, adult primary care, and psychiatric providers treating pregnant or postpartum women with depression and other mental health concerns up to one year after delivery.
- C. Maintain MCPAP teams with optimal staffing patterns to ensure effective team functioning and quality services. Team structure including FTE allocations must be approved by DMH.
- D. Ensure that MCPAP and MCPAP for Moms services are available statewide.
- E. In collaboration with DMH, conduct an analysis to identify the underlying causes for the decrease in MCPAP utilization from FY16 to FY17. The

analysis to include, but not limited to the following: examine enrolled PCP's experience with MCPAP services, as well as MCPAP team functioning and processes. It should also attempt to obtain feedback from enrolled PCPs who have not used MCPAP in the past year. This analysis will identify areas for quality improvement.

- F. In collaboration with DMH, develop, implement, and maintain a continuous quality improvement system capable of systematically collecting and analyzing data and information to ensure MCPAP and MCPAP for Mom's services are high quality, efficient, and meeting the needs of enrolled providers. This CQI system must include the following elements:

1. Information systems that collect reliable and accurate data;
2. Clearly defined quality indicators, metrics, and benchmarks that are guided by a logic model;
3. Rigorous methods for collecting both quantitative and qualitative data; and
4. Analysis of quality data to inform programmatic improvements.

- G. Contract with a sufficient number of MCPAP Teams to ensure continuous access for PCPs between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays) including the following:

1. Immediate advice within 30 minutes of the contact or within the time requested by the PCP: 95% of all calls to MCPAP and MCPAP for Moms should be responded to within this time frame;
2. Referral of patient to the team to provide information about local community Behavioral Health services: 95% of referrals should result in initial family contact within 48 hours; and
3. Referral of the patient to the team psychiatrist for diagnostic or psychopharmacologic assessment within 10 business days or, for MCPAP, to the team behavioral health clinician for non-psychopharmacologic assessment within 5 business days. Assess monthly, the wait time for first and second next appointments and implement a corrective action plan if wait is greater than (ten) 10 business days consistently for a quarter.

- H. Perform the following ongoing MCPAP responsibilities, without limitation:
1. Collect Encounter data pursuant to the Contractor's requirements;
 2. Conduct outreach to recruit, enroll, and build relationships with pediatric PCP and obstetric practices;
 3. Inform pediatric PCP and obstetric practices in a MCPAP Team's region how to access MCPAP services;
 4. Annually communicate with pediatric PCPs and obstetric providers regarding satisfaction with MCPAP;
 5. Every six (6) months communicate with pediatric PCPs and obstetric providers who have not used MCPAP programs in the past six months to identify barriers to using the MCPAP service, unless instructed otherwise by the practice with the practice's reasons for not using being logged;
 6. Maintain up-to-date and comprehensive information for PCCs on access to Network Behavioral Health Providers;
 7. Maintain program-specific dedicated websites about MCPAP and MCPAP for Moms programs that provides information about the programs and information about behavioral health topics and resources for PCPs, obstetric providers, and families; and
 8. Provide practice-based education and training on managing behavioral health in primary care.
- I. Submit monthly, quarterly, and annual aggregate progress reports to EOHHS and DMH 20 days after the closing of each relevant time period, which shall include the following data elements at the frequency noted:
1. Composition of MCPAP program teams for MCPAP and MCPAP for Moms including staffing and their FTEs (Annually);
 2. Number of PCPs and PCP practices enrolled in MCPAP and number of obstetric practices and provider enrolled in MCPAP for Moms (Monthly);
 3. During the quarter beginning March 2018, a list of pediatric MassHealth PCCs, noting which PCCs have enrolled in MCPAP

and which PCCs have not yet enrolled and noting efforts to enroll each unenrolled PCC (Quarterly);

4. For each MCPAP Team and statewide: number of Encounters by type of Encounter, diagnosis, reason for contact, and insurance status of the child. Quarterly and annual reports should show quarterly trends in number of encounters by type of encounter for three years (Monthly, Quarterly, and Annually);
 5. For each MCPAP Team and statewide: unduplicated count of members served, by type of Encounter and insurance status of the member. Quarterly and annual reports should show quarterly trends in number of members served for three years (Monthly, Quarterly, and Annually);
 6. Provide an analysis of degree of variation of specific PCPs with specific consultants (Annually);
 7. Average number of encounters per unduplicated Members, by MCPAP Team and statewide (Monthly);
 8. Number of enrolled PCPs, by MCPAP Team and number of enrolled obstetric providers in MCPAP for Moms (Monthly);
 9. Revenue generated by billing insurers, including Mass Health and MassHealth MCOs, for direct face-to-face treatment to children and families by MCPAP Provider and statewide (Quarterly);
 10. Other program utilization data elements that may be identified by EOHHS, MCPAP and DMH in response to quality improvement initiatives or policy questions; and
 11. Additional MCPAP reporting requirements as directed by EOHHS and DMH.
- J. Submit annual itemized budgets for each MCPAP Program Provider and MCPAP central administration by July 1st of each calendar year, and whenever there is a change in the budget.
- K. Coordinate all MCPAP program activities with DMH, including but not limited to:
1. Attending monthly planning meetings and other meetings as required by DMH;

2. Establishing and regularly convening a MCPAP Advisory Committee to inform and advise MCPAP and DMH on program improvements and direction;
 3. Revising program activities as requested by DMH and approved by EOHHS; and
 4. Participating in any DMH-initiated program evaluation activities and accompanied recommendations for future direction.
- L. Collaborate with DMH to implement financial and programmatic strategies to ensure sustainability of MCPAP within the context of alternative payment and service delivery methodologies associated with healthcare.”

4. **Section 4.9.B** is hereby amended by adding at the end therein the following subsection:-

“4. Alternative to Lock-up Program – See definition in **Section 1.1.**”

5. **Section 4.9.D** is hereby amended by striking it in its entirety and replacing it with the following:-

“D. Implementation Timeline

Reserved.”

6. **Section 4.9.G** is hereby amended by striking it in its entirety and replacing it with the following:-

“G. Contractor Payment to ESPs for MCI/RAP

1. Each state fiscal year, the Contractor shall pay each contracted ESP an annual base rate as defined in **Appendix H-1** for its operation of the MCI/RAP. The base rate shall include all administrative cost including:
 - a. Staff recruitment;
 - b. Staff reimbursement including fringe and benefits where applicable;
 - c. Scheduling;
 - d. Training;
 - e. Outreach to police and ALPs;
 - f. Follow-up with police/ALPs;
 - g. Coordination as needed with probation;
 - h. Coordination as needed with United Way 211, or other 24/7 information and referral provider; and

- i. documentation reporting requirements including but not limited to submission of quarterly data.
 2. The Contractor shall pay the base rate annually.
 3. The Contractor shall make the payments in **Section 4.9.G.1**, and shall account for any other costs associated with operation of the MCI/RAP, using only the payments EOHHS provides the Contractor in accordance with Section 10.12 and the Contractor's own funds. The Contractor shall not use any other payments EOHHS provides the Contractor in accordance with Section 10 to operate the MCI/RAP. Unless specifically directed to do so by EOHHS, the Contractor shall not include the Contractor's costs and expenditures related to the MCI/RAP in its Encounter Data submitted to EOHHS and such costs and expenditures shall not be considered when calculating any payment pursuant to the risk sharing arrangement in **Section 10.6 and Appendix H-1.**"
7. **Section 4.12** is hereby amended by striking it in its entirety and replacing it with the following:-
- "A. The Contractor shall provide specialized Inpatient Services for Covered Individuals under the age of 21 with Autism Spectrum Disorder or Intellectual or Developmental Disability (ASD/IDD) in specialized ASD/IDD inpatient treatment settings, as directed by EOHHS.
 - B. The Contractor shall report claims paid for Inpatient Services delivered to Covered Individuals under the age of 21 in specialized ASD/IDD inpatient treatment settings to EOHHS in a form and format and at a frequency to be determined by EOHHS."

SECTION 6. INTEGRATION OF CARE

1. **Section 6.2.I** is hereby amended by deleting it in its entirety and replacing it with the following:-

"During Contract Year 2018, the Contractor shall partner with EOHHS to develop and execute a transition plan for MBHP members including but not limited to ICMP and PBCM Members who are identified by EOHHS for future enrollment in an ACO or CP. This plan shall include but not be limited to, Member-specific transitional "handoff" meetings between MBHP (including ICMP/PBCM members) and ACOs or CPs."

SECTION 8. QUALITY MANAGEMENT (QM)

1. **Section 8.9.A.5.c** is hereby amended by striking it in its entirety and replacing it with the following:-

- “c. Unless otherwise directed by EOHHS, annually evaluate at least 10% of the Covered Individuals under the age of 21 who have received Outpatient services during each Contract Year, consisting of a mix of Outpatient providers, provided however that the Contractor shall not be required to review more than 10 Covered Individual’s medical files per region per Contract Year.”

SECTION 10. PAYMENT AND FINANCIAL PROVISION

1. **Section 10.2** is hereby amended by deleting it in its entirety and replacing it with the following:-

“Section 10.2 Rating Categories (RC) for Covered Individuals

A. RC I (Families) Adults

RC I Adults includes MassHealth Members between the ages of 21 and 65 who are enrolled in MassHealth Standard, including individuals receiving Transitional Aid to Families with Dependent Children (TAFDC) benefits; MassHealth Members who are categorically related to the TAFDC program, (excluding spend-down cases); MassHealth Members between the ages of 21 and 65 under the Refugee Resettlement Program, MassHealth Members in MassHealth (Family Assistance); RC I Adults excludes individuals who have Third-Party Liability coverage.

B. RC I Children (Families)

RC I Children include MassHealth members under the age of 21 who are enrolled in MassHealth Standard, including individuals receiving Transitional Aid to Families with Dependent Children (TAFDC) benefits; MassHealth Members who categorically related to the TAFDC program, (excluding spend-down cases); MassHealth Members from the age of 0 through age 20 under the Refugee Resettlement Program, MassHealth Members in MassHealth (Family Assistance); RC I Children excludes individuals who have Third-Party Liability coverage.

C. RC I Children under 21 with TPL Only

RC I Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard under age 21 with Third- Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

D. RC II (Disabled) Adults

RC II Adults includes: MassHealth Members between the age of 21 and 65 who are disabled and receiving Supplemental Security Income (SSI), excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members who are disabled, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members receiving SSI and Massachusetts Commission for the Blind benefits, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits;

MassHealth Members of the Massachusetts Commission for the Blind excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Standard (Disabled) Members; and Members of MassHealth CommonHealth who have no Third-Party Liability coverage.

E. RC II Children (Disabled)

RC II Children includes: MassHealth Member under the age of 21 who are disabled and receiving Supplemental Security Income (SSI), excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members who are disabled, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members receiving SSI and Massachusetts Commission for the Blind benefits, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members of the Massachusetts Commission for the Blind excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Standard (Disabled) Members; and Members of MassHealth CommonHealth who have no Third-Party Liability coverage.

F. RC II Children under 21 with TPL Only

RC II Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard (Disabled) and CommonHealth under age 21 with Third-Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

G. RC VIII (MFP)

RC VIII includes MassHealth Members enrolled in one of the two HCBS waivers called the MFP Community Living (MFP-CL) (HCBSG Benefit Plan) Waiver and MFP Residential Supports (MFP-RS) (HCBSH Benefit Plan) Waiver.

H. RC IX (CarePlus)

RC IX includes Covered Individuals over the age of 20 and under the age of 65 with incomes up to 133 percent of the Federal Poverty Level (FPL), who are not pregnant, disabled, or a parent or a caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC IX are individuals who are dually-eligible for Medicaid and Medicare.

I. RC X (CarePlus)

RC X includes Covered Individuals over the age 20 and under the age of 65 with incomes up to 133 percent of the FPL, who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. Excluded from RC X are individuals who are pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other

MassHealth coverage. Also excluded from RC X are individuals who are dually eligible for Medicaid and Medicare.”

2. **Section 10.5** is hereby amended by adding at the end therein the following subsection:-

“C. Payment Methodology for Specialized Psychiatric Inpatient Services Claims

1. EOHHS shall make payments to the Contractor for specialized psychiatric inpatient services claims specified in **Section 4.12** on a quarterly basis using a per diem rate specified in **Appendix H-1**. The Contractor shall provide claims data in a format and at a frequency specified by EOHHS to assist with calculation of the quarterly payment amount.”

3. **Section 10.6** is hereby amended by adding at the end therein the following subsections:-

“B. Primary Care ACO

1. There may be distinct risk-sharing arrangements for the services delivered to an individual enrolled in a Primary Care ACO as set forth in Appendix H-1.
2. The arrangement described in this Section 10.6.B may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.
3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor’s expenditures related to individuals enrolled in a Primary Care ACO, as determined by EOHHS.

C. Applied Behavioral Analysis.

1. There may be distinct risk-sharing arrangements for the Applied Behavioral Analysis services as set forth in **Appendix H-1**.
2. The arrangement described in this **Section 10.6.C** may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.
3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor’s expenditures related to Covered Individuals, as determined by EOHHS.

D. CBHI

1. There may be distinct risk-sharing arrangement for the CBHI Services.

2. The arrangement described in this **Section 10.6.D** may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.
3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor's expenditures related to Covered Individuals, as determined by EOHHS.

E. Substance Use Disorders

1. There may be distinct risk-sharing arrangement for the SUD Level 3.1 and 3.3 services.
2. The arrangement described in this **Section 10.6.E** may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.
3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor's expenditures related to Covered Individuals, as determined by EOHHS."

4. **Section 10.13** is hereby amended by deleting subsections C and D in their entirety.

SECTION 13. CONTRACT TERM

1. **Section 13.15** is hereby amended by deleting it in its entirety and replacing it with the following:-

"The Contract is effective upon execution, through December 31, 2018, unless otherwise terminated or extended in accordance with this section or at such other time that EOHHS may implement changes that render the performance of the Contract unnecessary. At EOHHS's option, the Contract may be extended for up to five additional years from June 30, 2017, at the discretion of EOHHS, and in increments and upon terms to be negotiated by the parties."

APPENDICES

1. **Appendix A-1** is hereby amended by deleting it in its entirety and replacing it with the **Appendix A-1** attached hereto.
2. **Appendix G** is hereby amended by deleting it its entirety and replacing it with the **Appendix G** attached hereto.
3. **Appendix H-1** is hereby amended by deleting it its entirety and replacing it with the **Appendix H-1** attached hereto.

APPENDIX A-1

Covered Services

I. Behavioral Health Covered Services for Standard and CommonHealth Covered Individuals

- A. Inpatient Services** – 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.
- 1. Inpatient Mental Health Services** – hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.
 - 2. Medically Managed Inpatient Substance Use Disorder Services (Level 4)** – Intensive inpatient services provided in a hospital setting, able to treat Covered Individuals with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credential physicians and other appropriate credential treatment professionals with the full resources of a general acute care or psychiatric hospital available.
 - 3. Observation/Holding Beds** – hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Covered Individuals.
 - 4. Administratively Necessary Day (AND) Services** – a day(s) of inpatient hospitalization provided to Covered Individuals when said Covered Individuals are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.
- B. Diversionary Services** – those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.
- 1. 24-Hour Diversionary Services:**
 - a. Community Crisis Stabilization** – services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
 - b. Community-Based Acute Treatment for Children and Adolescents (CBAT)** – mental health services provided in a staff-secure setting on a 24-hour basis, with

sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.

- c. **Medically Monitored Intensive Services – Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)** – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management services delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures. Services include bio-psychosocial assessment; induction to FDA approved medications for addictions when appropriate, individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.
- d. **Clinical Support Services for Substance Use Disorders (Level 3.5)** – 24-hour treatment services including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive psychoeducation education and counseling; outreach to families and significant others; linkage to medications for addiction therapy, connection to primary care and community supports, and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.
- e. **Clinically Managed Population-Specific High Intensity Residential Services (Level 3.3)** – 24 hour structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of patients with cognitive impairments who may be unable, or have difficulty, participating in treatment that is primary cognitively based. Level 3.3 programs focus on a tailored treatment approach to serve individuals with developmental delays, traumatic brain injuries, fetal alcohol spectrum disorder, and others who require a high intensity, repetition based, or non-cognitive clinical and recovery protocol and environment.
- f. **Transitional Support Services (TSS) for Substance Use Disorders (Level 3.1)** – 24 hour, short term intensive case management and psycho-educational residential programming with nursing available for Covered Individuals requiring short term placements. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.

- g. Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)** – 24 hour structured and comprehensive rehabilitative environment that supports Covered Individual's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Specialized RRS services tailored for the needs of Youth, Transitional Age Youth, Young Adults, Families and Pregnant and Post-Partum Women are also available to eligible Covered Individuals.
- h. Enhanced Residential Rehabilitation Services for Dually Diagnosed (Level 3.1 co-occurring enhanced)** – 24 hour residential environment intended to serve Covered Individuals with higher levels of complexity and acuity, including co-occurring substance use and mental health disorders. Programs are staffed to adequately identify and treat both substance use and mental health disorders in an integrated fashion. Programs are expected to provide holistic and integrated care that facilitates access to medications for addiction treatment (MAT), primary care and medical supports, and psychiatric care as needed.
- i. Transitional Care Unit (TCU)** – A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies

2. Non-24-Hour Diversionary Services

- a. Community Support Program (CSP)** – an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.
- b. Recovery Coaching** – Recovery Coaching is a non-clinical service provided by individuals currently in recovery from a substance use disorders and who have been trained to help people struggling with a similar experience (their peers) to gain hope, explore recovery and achieve life goals. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Members to recovery community and serving as a personal guide and mentor.

- c. **Recovery Support Navigators (RSN)** – RSN services are specialized care coordination services intended to engage Covered Individuals in accessing substance use disorder treatment, facilitating smooth transitions between levels of care, support Covered Individuals in obtaining service that facilitate recovery. Recovery Support Navigators coordinate with other substance use disorder treatment providers, as well as primary care and prescribers of medications for addiction therapy (MAT) in support of Covered Individuals.
- d. **Partial Hospitalization (PHP)** – an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.
- e. **Psychiatric Day Treatment** – services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.
- f. **Structured Outpatient Addiction Program (SOAP)** – clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.
- g. **Program of Assertive Community Treatment (PACT)** – shall mean a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.
- h. **Intensive Outpatient Program (IOP)** - a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.

C. Outpatient Services – mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home or school.

1. Standard outpatient Services – those Outpatient Services most often provided in an ambulatory setting.

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

- h. Couples/Family Treatment** – the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.
- i. Group Treatment** – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.
- j. Individual Treatment** – the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.
- k. Inpatient-Outpatient Bridge Visit** – a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.
- l. Assessment for Safe and Appropriate Placement (ASAP)** – an assessment, required by MGL 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of DSS and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a DSS designated ASAP provider.
- m. Collateral Contact** – a communication of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of an Enrollee under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.
- n. Acupuncture Treatment** – the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.
- o. Opioid Treatment Services** – supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses detoxification treatment and maintenance treatment.
- p. Withdrawal Management (Level 2WM)** – outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications, but do not require a 24 hour settings. Ambulatory Withdrawal Management is provided under the direction of a physician and is designed to

stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.

- q. **Psychological Testing** – the use of standardized test instruments to assess a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.
 - r. **Special Education Psychological Testing** – psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass Gen. Law 71B, and which shall be utilized toward the development of an Individualized Educational Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.
2. **Intensive Home or Community-Based Services for Youth** – mental health and substance use disorder services provided to Covered Individuals in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service.
- a. **Family Support and Training** – a service provided to the parent /caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home and other community settings. Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning. Services may include education, assistance in navigating the child serving systems; fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources, support, coaching, and training for the parent/caregiver.
 - b. **Intensive Care Coordination** – a service that provides targeted case management services to individuals under 21 with a Serious Emotional Disturbance including individuals with co-occurring conditions. This service includes assessment, development of an individualized care plan, referral and related activities to implement the care plan and monitoring of the care plan.
 - c. **In-Home Behavioral Services** – this service usually includes a combination of behavior management therapy and behavior management monitoring, as follows:
 - C1. Behavior Management Therapy:** This service includes assessment, development of the behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance. This

service addresses challenging behaviors which interfere with the child's successful functioning. The behavior management therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, which are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and level of intervention required. Phone contact and consultation may be provided as part of the intervention.

C2. Behavior Management Monitoring: This service includes implementation of the behavior plan, monitoring the child's behavior, reinforcing implementation of the plan by parents or other caregivers and reporting to the behavior management therapist on implementation of the plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.

d. In-Home Therapy Services – This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:

D1. The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the child's mental health needs including improving the family's ability to provide effective support for the child to promote healthy functioning of the child within the family. The clinician develops a treatment plan and, using established psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals.

D2. Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.

e. Therapeutic Mentoring Services - This service provides a structured, one-to-one mentoring relationship between a therapeutic mentor and a child or adolescent for the purpose of addressing daily living, social and communication needs. Each child or adolescent will have goals and objectives that are designed to support age-appropriate social functioning or ameliorate deficits in the child or adolescent's age-appropriate social functioning. These goals and objectives are developed by the child or adolescent, as appropriate, and his/her treatment team and are incorporated into the treatment plan. The service includes supporting, coaching and training the child or

adolescent in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities. The therapeutic mentor works with the child or adolescent in such settings as their home, school or social or recreational activities.

D. Emergency Services Program (ESP) - services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.

- 1. ESP Encounter** - each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization.
 - a. Assessment** - a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;
 - b. Intervention** –the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and
 - c. Stabilization** – short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.

In addition, medication evaluation and specialing services shall be provided if Medically Necessary.

- 2. Youth Mobile Crisis Intervention** - a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.

E. Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type.

- 1. Electro-Convulsive Therapy (ECT)** - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.
- 2. Specialing** - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.
- 3. Applied Behavioral Analysis for members under 21 years of age** - a well-developed scientific discipline among the helping professions that focuses on the analysis, design,

implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior.

II. Behavioral Health Covered Services for Family Assistance Covered Individuals

- A. Inpatient Services** - 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.
- 1. Inpatient Mental Health Services** - hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.
 - 2. Medically Managed Inpatient Substance Use Disorder Services (Level 4)** - Intensive inpatient services provided in a hospital setting, able to treat Covered Individuals with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credential physicians and other appropriate credential treatment professionals with the full resources of a general acute care or psychiatric hospital available.
 - 3. Observation/Holding Beds** - hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Covered Individuals.
 - 4. Administratively Necessary Day (AND) Services** - a day(s) of inpatient hospitalization provided to Covered Individuals when said Covered Individuals are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.
- B. Diversionary Services** - those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.
- 1. 24-Hour Diversionary Services:**
 - a. Community Crisis Stabilization**— services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services.
 - b. Community-Based Acute Treatment for Children and Adolescents (CBAT)** – mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication

monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.

- c. **Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)** – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management services delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures. Services include bio-psychosocial assessment; induction to FDA approved medications for addictions when appropriate, individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.
- d. **Clinically Managed High-Intensity Residential Services - Clinical Support Services for Substance Use Disorders (Level 3.5)** – 24-hour treatment services including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive psychoeducation education and counseling; outreach to families and significant others; linkage to medications for addiction therapy, connection to primary care and community supports, and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.
- e. **Clinically Managed Population-Specific High Intensity Residential Services (Level 3.3)** – 24-hour structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of patients with cognitive impairments who may be unable, or have difficulty, participating in treatment that is primary cognitively based. Level 3.3 programs focus on a tailored treatment approach to serve individuals with developmental delays, traumatic brain injuries, fetal alcohol spectrum disorder, and others who require a high intensity, repetition based, or non-cognitive clinical and recovery protocol and environment.
- f. **Transitional Support Services (TSS) for Substance Use Disorders (Level 3.1)** – 24 hour, short term intensive case management and psycho-educational residential programming with nursing available for Covered Individuals requiring short term placements. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.

- g. Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)** - 24 hour structured and comprehensive rehabilitative environment that supports Covered Individual's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Specialized RRS services tailored for the needs of Youth, Transitional Age Youth, Young Adults, Families and Pregnant and Post-Partum Women are also available to eligible Covered Individuals
- h. Enhanced Residential Rehabilitation Services for Dually Diagnosed (Level 3.1 co-occurring enhanced)** – 24-hour residential environment intended to serve Covered Individuals with higher levels of complexity and acuity, including co-occurring substance use and mental health disorders. Programs are staffed to adequately identify and treat both substance use and mental health disorders in an integrated fashion. Programs are expected to provide holistic and integrated care that facilitates access to medications for addiction treatment (MAT), primary care and medical supports, and psychiatric care as needed.
- i. Transitional Care Unit (TCU)** – A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies.

2. Non-24-Hour Diversionary Services

- a. Community Support Program (CSP)** - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.
- b. Recovery Coaching** - Recovery Coaching is a non-clinical service provided by individuals currently in recovery from a substance use disorders and who have been trained to help people struggling with a similar experience (their peers) to gain hope, explore recovery and achieve life goals. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Members to recovery community and serving as a personal guide and mentor.

- c. **Recovery Support Navigators (RSN)** – RSN services are specialized care coordination services intended to engage Covered Individuals in accessing substance use disorder treatment, facilitating smooth transitions between levels of care, support Covered Individuals in obtaining service that facilitate recovery. Recovery Support Navigators coordinate with other substance use disorder treatment providers, as well as primary care and prescribers of medications for addiction therapy (MAT) in support of Covered Individuals.
- d. **Partial Hospitalization (PHP)** - an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.
- e. **Psychiatric Day Treatment** - services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.
- f. **Structured Outpatient Addiction Program (SOAP)** - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring.
- g. **Program of Assertive Community Treatment (PACT)** shall mean a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.
- h. **Intensive Outpatient Program (IOP)** - a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.

- C. Outpatient Services** - mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home or school.

1. Standard Outpatient Services – those Outpatient Services most often provided in an ambulatory setting.

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

- h. **Couples/Family Treatment** - the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.
- i. **Group Treatment** – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.
- j. **Individual Treatment** - the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.
- k. **Inpatient-Outpatient Bridge Visit** - a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.
- l. **Assessment for Safe and Appropriate Placement (ASAP)** - an assessment, required by MGL 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of DSS and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a DSS designated ASAP provider.
- m. **Collateral Contact** - a communication of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of an Enrollee under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.
- n. **Acupuncture Treatment** - the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.
- o. **Opioid Treatment Services** — supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses detoxification treatment and maintenance treatment.
- p. **Ambulatory Withdrawal Management (Level 2WM)** - outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications, but do not require a 24 hour settings. Ambulatory Withdrawal Management is provided under the direction of a physician and is

designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.

- q. Psychological Testing** - the use of standardized test instruments to assess a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.
 - r. Special Education Psychological Testing** - psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass. Gen. Law 71B, and which shall be utilized toward the development of an Individualized Educational Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.
- 2. Intensive Home or Community-Based Services for Youth** – mental health and substance use disorder services provided to Covered Individuals in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service.
 - a. In-Home Therapy Services. This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:**
 - A1.** The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the child's mental health needs including improving the family's ability to provide effective support for the child to promote healthy functioning of the child within the family. The clinician develops a treatment plan and, using established psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals.
 - A2.** Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.

D. Emergency Services Program (ESP) - services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.

- 1. ESP Encounter** - each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization.
 - a. Assessment** - a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;
 - b. Intervention** –the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and
 - c. Stabilization** – short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.

In addition, medication evaluation and specializing services shall be provided if Medically Necessary.

- 2. Youth Mobile Crisis Intervention** - a short term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.

E. Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type.

- 1. Electro-Convulsive Therapy (ECT)** - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.
- 2. Specializing** - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.
- 3. Applied Behavioral Analysis for members under 21 years of age** - a well-developed scientific discipline among the helping professions that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior.

III. Behavioral Health Services for CarePlus Enrollees

- A. Inpatient Services** - 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.
- 1. Inpatient Mental Health Services** - hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.
 - 2. Medically Managed Inpatient Substance Use Disorder Services (Level 4)** - Intensive inpatient services provided in a hospital setting, able to treat Covered Individuals with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credential physicians and other appropriate credential treatment professionals with the full resources of a general acute care or psychiatric hospital available.
 - 3. Observation/Holding Beds** - hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Enrollees.
 - 4. Administratively Necessary Day (AND) Services** - a day(s) of inpatient hospitalization provided to Enrollees when said Enrollees are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.
- B. Diversionary Services** - those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility.
- 1. 24-Hour Diversionary Services**
 - a. Community Crisis Stabilization** - services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Enrollees who do not require Inpatient Services.
 - b. Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)** – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management services delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures. Services include bio-psychosocial assessment; induction to FDA approved medications for addictions when appropriate, individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance

use disorder treatment and obstetrical care until disenrolled from CarePlus. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.

- c. **Clinically Managed High-Intensity Residential Services - Clinical Support Services for Substance Use Disorders (Level 3.5)** – 24-hour treatment services including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive psychoeducation education and counseling; outreach to families and significant others; linkage to medications for addiction therapy, connection to primary care and community supports, and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care until disenrolled from CarePlus.
- d. **Clinically Managed Population-Specific High Intensity Residential Services (Level 3.3)** - 24 hour structured recovery environment in combination with high-intensity clinical services provided in a manner to meet the functional limitations of patients with cognitive impairments who may be unable, or have difficulty, participating in treatment that is primary cognitively based. Level 3.3 programs focus on a tailored treatment approach to serve individuals with developmental delays, traumatic brain injuries, fetal alcohol spectrum disorder, and others who require a high intensity, repetition based, or non-cognitive clinical and recovery protocol and environment.
- e. **Transitional Support Services (TSS) for Substance Use Disorders (Level 3.1)** – 24 hour, short term intensive case management and psycho-educational residential programming with nursing available for Covered Individuals requiring short term placements. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.
- f. **Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)** – RRS services under CY2018 have a staggered start date and coverage will begin for these services on March 1, 2018. 24-hour structured and comprehensive rehabilitative environment that supports Covered Individual's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Specialized RRS services tailored for the needs of Youth, Transitional Age Youth, Young Adults, Families and Pregnant and Post-Partum Women are also available to eligible Covered Individuals.

- g. **Enhanced Residential Rehabilitation Services for Dually Diagnosed (Level 3.1 co-occurring enhanced)** – 24-hour residential environment intended to serve Covered Individuals with higher levels of complexity and acuity, including co-occurring substance use and mental health disorders. Programs are staffed to adequately identify and treat both substance use and mental health disorders in an integrated fashion. Programs are expected to provide holistic and integrated care that facilitates access to medications for addiction treatment (MAT), primary care and medical supports, and psychiatric care as needed.

2. Non-24-Hour Diversionary Services

- a. **Community Support Program (CSP)** - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Enrollees with a long standing history of a psychiatric or substance use disorder and to their families, or to Enrollees who are at varying degrees of increased medical risk, or who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.
- b. **Recovery Coaching** - Recovery Coaching is a non-clinical service provided by individuals currently in recovery from a substance use disorders and who have been trained to help people struggling with a similar experience (their peers) to gain hope, explore recovery and achieve life goals. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Members to recovery community and serving as a personal guide and mentor.
- c. **Recovery Support Navigators (RSN)** – RSN services are specialized care coordination services intended to engage Covered Individuals in accessing substance use disorder treatment, facilitating smooth transitions between levels of care, support Covered Individuals in obtaining service that facilitate recovery. Recovery Support Navigators coordinate with other substance use disorder treatment providers, as well as primary care and prescribers of medications for addiction therapy (MAT) in support of Covered Individuals.
- d. **Partial Hospitalization (PHP)** - an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.
- e. **Psychiatric Day Treatment** - services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.

- f. **Structured Outpatient Addiction Program (SOAP)** - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women (until disenrolled from CarePlus), and adults requiring 24-hour monitoring.
- g. **Intensive Outpatient Program (IOP)** - a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.

C. Outpatient Services - mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home.

- 1. **Standard Outpatient Services** – those outpatient services most often provided in an ambulatory care setting.
- 2. **Family Consultation** - a meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.
- 3. **Case Consultation** - an in-person or by telephone meeting of at least 15 minutes' duration, between the treating Provider and other behavioral health clinicians or the Enrollee's primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.
- 4. **Diagnostic Evaluation** - an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.
- 5. **Dialectical Behavioral Therapy (DBT)** - a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Enrollees with borderline personality disorder who also exhibit chronic and parasuicidal behaviors. DBT may be

used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.

6. **Psychiatric Consultation on an Inpatient Medical Unit** - an in- person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.
7. **Medication Visit** - an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.
8. **Couples/Family Treatment** - the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.
9. **Group Treatment** – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.
10. **Individual Treatment** - the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.
11. **Inpatient-Outpatient Bridge Visit** - a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.
12. **Acupuncture Treatment** - the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.
13. **Opioid Treatment Services** — supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses detoxification treatment and maintenance treatment.
14. **Ambulatory Withdrawal Management (Level 2WM)** - outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications, but do not require a 24 hour settings. Ambulatory Withdrawal Management is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will

determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.

15. Psychological Testing - the use of standardized test instruments to assess a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.

D. Emergency Services Program (ESP) - services that are provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.

1. ESP Encounter - each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization.

a. Assessment - a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;

b. Intervention - the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and

c. Stabilization - short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care.

In addition, medication evaluation and specializing services shall be provided if Medically Necessary.

E. Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type.

1. Electro-Convulsive Therapy (ECT) - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.

2. Specialing - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.

IV. ESP SERVICES FOR UNINSURED INDIVIDUALS AND PERSONS COVERED BY MEDICARE ONLY

A. The Contractor shall deliver the following Medically Necessary Services to Uninsured Individuals and persons covered by Medicare only:

1. Emergency Services Program (ESP) Services - services that are provided through designated contracted ESPs, and which are available seven days per week, 24 hours per

day to provide treatment of any individual who is an Uninsured Individual or an individual insured by Medicare only and is experiencing a mental health crisis.

2. **ESP Encounter** shall mean each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include, at a minimum: Crisis Assessment, Intervention, and Stabilization.
 - a. **Crisis Assessment:** a face-to-face evaluation of an individual presenting with a Behavioral Health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel;
 - b. **Intervention:** the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency;
 - c. **Stabilization:** short-term Behavioral Health treatment in a structured environment with continuous observation and supervision of individuals who do not require a hospital Level of Care.

In addition, medication evaluation and specializing services shall be provided if medically necessary.

- B. **Youth Mobile Crisis Intervention** shall mean a short-term, mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a Behavioral Health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Such services are available 24 hours a day, seven days a week.

APPENDIX G

BEHAVIORAL HEALTH PERFORMANCE INCENTIVES (SECTION 8.6.C)

Effective Contract Year 2018

Introduction

The performance-based incentives for Contract Year 2018 are summarized below. The summary includes baseline criteria, population descriptions, project goals, specific performance targets, and associated available earnings. For the purposes of this Appendix, a member is “Enrolled” in the CMP if the Contractor has had one or more in-person or telephonic encounter(s) with the Enrollee, for the purposes of completing a comprehensive health assessment, creating and implementing an Individual Care Plan (ICP). Such encounters occur at a frequency dependent on the clinical needs of the Participant.

The earnings associated with each performance-based incentive correspond with the degree of the Contractor’s success in meeting the established incremental goals. The measure of the Contractor’s success for each performance-based incentive is described in detail below. For each performance-based incentive, levels of success are associated with levels of payment, referred throughout this document as “Performance and Payment Levels.” The Contractor shall only be paid the single amount listed in the single level which corresponds to the actual results achieved based on the measurement methodologies.

Methodology

The Contractor shall design a project methodology, for review and approval by EOHHS, for each of the performance-based incentives **Appendix G**. Each methodology shall further define and clarify the purposes, goals and deliverables associated with each incentive, and shall provide the technical specification for each measurement. Elements to be defined include, at minimum: baseline, denominator, numerator, continuous eligibility requirements, measurement period, population exclusions, deliverables, and final reporting schedules. EOHHS will use **Appendix G** and the project methodology when reviewing the results of each project to determine the amount of incentive payments, if any, the Contractor has earned. For all measures, the measurement period for the calculation of results shall conform with the Contract Year period.

Developing the Baseline and Percent Change

The Contractor shall produce all required baseline measurements, and shall use the same methodology when producing the repeat measurements for non-HEDIS indicators. The Contractor shall follow this methodological pattern in each Contract Year. For HEDIS measures, HEDIS Technical Specifications will be used for the performance-based incentives

corresponding to each measurement year. For Contract Year 2018, the Contractor shall refer to the technical measure specifications for HEDIS 2018:

<http://ncqa.org/Portals/0/HEDISQM/HEDIS2018/HEDIS%202018%20Measures.pdf?ver=2017-06-28-134644-370>

The performance level benchmarks must correspond to the national NCQA Medicaid HEDIS percentiles.

To the extent that the payment described in each level is an incremental percentage change over a baseline rate, such incremental change is a “relative” change.

Example: a baseline rate of 50% with a relative 5% improvement would result in a new rate of $(0.50 \times 1.05 \times 100) = 52.5\%$. Fractional rates shall be rounded to the nearest whole number.

Incentive 1. Initiation and Engagement in Alcohol and Other Drug Dependence Treatment (HEDIS measure: IET)

Goal Statement: The Contractor shall continue to deploy a new model of care integration and Member Engagement to improve the rate at which Covered Individuals enter and sustain participation in treatment for alcohol and other drug dependence through effective interventions that involve Members, their families, Providers, doctors, ED facilities, and community supports.

Technical Specifications:

The technical specifications for this measure, including the denominator and numerator definitions, shall conform to the HEDIS IET specifications updated and published by NCQA annually, and shall be applied to the measurement period corresponding to the current the Contract Year.

The Contractor shall report on the rate of treatment for alcohol and other drug diagnoses as per the updated HEDIS 2018 measure specification.

Measure	Tier 2 Goal	Tier 1 Goal
M1. the rate for the initiation of treatment of AOD treatment per HEDIS 2018 specifications	greater than or equal to the HEDIS 2017 50 th percentile \$125,000	greater than or equal to the HEDIS 2017 75 th percentile \$175,000

M2. the rate for Engagement in treatment of AOD treatment per HEDIS 2018 specifications	greater than or equal to the HEDIS 2017 50 th percentile \$125,000	greater than or equal to the HEDIS 2017 75 th percentile \$175,000
M3. A decrease of up to 1 percent in the rate of substance use disorder readmission within 90 days.	≥1% decrease from the 2017 rate \$225,000	≥1.5% decrease from the 2017 rate \$300,000

The maximum incentive payment for this P4P is \$ 650,000.

Incentive 2. Follow-up After Hospitalization for Mental Illness (HEDIS measure: FUH)

Goal Statement: The Contractor shall continue the model of care integration and Member Engagement (as described in **Section 6**) to improve the rate at which Covered Individuals who had been hospitalized for a mental illness receive timely and adequate mental health services aftercare using Behavioral Health Covered Services and reduction in the rate of re-hospitalization.

Technical Specifications:

- A. The technical specifications for measures one and two (M1 and M2), including the denominator and numerator definitions, shall conform to the HEDIS FUH specifications published by NCQA, and shall be applied to the measurement period corresponding to the current Contract Year. The contractor shall report performance as per the 2018 HEDIS measure specification.
- B. Within M3(A), the definition of *Readmission* shall mean the number of episode discharges from a mental health 24-hour Level of Care and the number of discharges that were followed by a subsequent admission to the same or equivalent 24-hour Level of Care within 0-90 days of the discharge date of the episode. Using the count of discharges and the count of readmissions, the rate of readmission is calculated.
- C. Within M4, the definition of “*arranged prior to discharge*” shall mean as evidenced within either the *MHS/Connect* (the Contractor’s clinical documentation application) or the Provider’s medical record, documentation of: Member and/or family involvement and agreement, the name of the Behavioral Health Covered Service, name of the Provider, and the date and time of the first appointment

Measure	Goals	
	Tier 2 Goal	Tier 1 Goal
M1. the rate for 7-day follow-up per HEDIS 2018 specifications	greater than or equal to the HEDIS 2017 50 th percentile \$50,000	greater than or equal to the HEDIS 2017 75 th percentile \$75,000
M2. the rate for 30-day follow-up per HEDIS 2018 specifications	greater than or equal to the HEDIS 2017 50 th percentile \$50,000	greater than or equal to the HEDIS 2017 75 th percentile \$75,000
M3(A). A decrease of up to 1.25 percent in the rate of mental health readmission within 90 days	≥ 0.75% decrease from the 2017 rate \$200,000	≥ 1.25% decrease from the 2017 rate \$250,000
M4. The rate for aftercare appointments being arranged prior to discharge as documented in Contractor's system	50%-79% rate \$75,000	≥80% rate \$150,000

The maximum incentive payment for this P4P is \$550,000.

Incentive 3. Follow-up for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication (HEDIS measure: ADD)

Goal Statement: The Contractor shall improve the treatment of Enrollees (6-12 years of age) who have been newly prescribed medication for ADHD, through follow-up care designed to result in effective symptom management, improved functional status of the Enrollee, and adherence to medication regimen.

Technical Specifications:

The technical specifications for this measure, including the denominator and numerator, shall conform to the HEDIS ADD specifications, updated and published by NCQA annually, and shall be applied to the measurement period corresponding to the current Contract Year.

Measure	Goal	
	Tier 2 Goal	Tier 1 Goal
M1. the rate for Initiation of Follow-up Care for Children Prescribed ADHD Medication per HEDIS 2018 specifications	greater than or equal to the HEDIS 2017 $\geq 50^{\text{th}}$ percentile \$75,000	greater than or equal to the HEDIS 2017 $\geq 75^{\text{th}}$ percentile \$100,000
M2. the rate for Continuation and Maintenance (C&M) of Follow-up Care for Children Prescribed ADHD Medication per HEDIS 2018 specifications	greater than or equal to the HEDIS 2017 $\geq 50^{\text{th}}$ percentile \$75,000	greater than or equal to the HEDIS 2017 $\geq 75^{\text{th}}$ percentile \$100,000

The maximum incentive payment for this P4P is \$200,000.

Incentive 4. Practice Based Care Management (PBCM) Engagement

Targets and Payment levels by December 31, 2018:

- A. If the Contractor increases the number of PCC Service Locations participating in PBCM to six (6) sites, it will receive \$40,000.
- B. If the Contractor increases the number of PCC Service Locations participating in PBCM to eight (8) or more sites, it will receive the \$40,000 described in Incentive 4.A, as well as an additional \$10,000.
- C. If the Contractor engages a total of 1100 unique Enrollees in PBCM, it will receive \$75,000.
- D. If the Contractor engages a total of 500 unique Enrollees in ICMP, it will receive \$75,000.

The maximum payment for this incentive is \$200,000.

Incentive 5. Service Integration Project for Covered Individuals Prescribed Antipsychotic Medication at Risk for Diabetes

- **Goal Statement:**

1. The Contractor shall continue to support and deliver interventions to improve the frequency of metabolic screenings, increase ongoing monitoring, and support diabetes

management for all Covered Individuals including children, adolescents and adults who are prescribed antipsychotic medication(s).

2. The Contractor shall continue to demonstrate that care integration and Covered Individuals Engagement will improve the care of Covered Individuals with diabetes, including DMH Clients, in accordance with clinical practice guidelines. The goal is to improve the rate of routine metabolic monitoring for Covered Individuals with diabetes, including DMH Clients. Routine metabolic monitoring is critical for those whose blood glucose levels, as measured through the HbA1c blood test, are < 8.0%; whose blood pressure is < 140/90 mm Hg; and who received a retinal eye examination and screening for nephropathy.
- The interventions will support behavioral health and medical integration as both delivery systems serve Covered Individuals on antipsychotics who are at increased risk for developing diabetes, including those with serious and persistent mental illness (SPMI).
 - The interventions will support access to evidence-based, integrated primary care among youth and adolescent clients with diagnosed diabetes as measured by HEDIS APM metabolic monitoring measure.

Deliverables: By December 31, 2018, the Contractor shall:

- 1) Identify all Covered Individuals receiving antipsychotic medications with HEDIS-based gaps in care for routine metabolic monitoring, including screening as well as, for youth, BMI, waist measurement, blood pressure, lipid, and glucose screening.
- 2) Identify 2-3 interventions for rapid cycle quality improvement with pediatric and adult-serving primary care entities, pharmacies, outpatient behavioral health providers, practice-based care management participants.
- 3) Provide trainings and/or educational campaigns for both PCC Plan and ACO Primary Care providers serving a large number of Covered Individuals prescribed antipsychotics and at impending risk of diabetes. Within 90 days of contract execution, the Contractor shall produce a proposed plan and calendar of events for such trainings and educational activities.
- 4) Leverage existing network management infrastructure for direct work with PCC Plan providers or other entities as appropriate on QI opportunities.

Within ninety (90) days of the end of the Contract Year, the Contractor shall:

- 1) Report and evaluate findings on:
 - a. Number of Covered Individuals screened for target interventions
 - b. Year to year comparison of calendar year 2018 verses calendar year 2017 performance on:

- i. SSD HEDIS measure
 - ii. APM HEDIS metabolic monitoring rates for youth
 - iii. HEDIS Diabetes composite measure
 - c. Number of patients in intervention groups that had annual follow up monitoring tests as compared to control
- 2) Report lessons learned from interventions
 - 3) Plan for improvements to existing quality work plan
 - 4) Discuss findings and opportunities for improvement with participating providers

Percent of maximum payment will be distributed as follows:

1) Identify all Covered Individuals receiving antipsychotic medications with HEDIS-based gaps in care for routine metabolic monitoring, including screening as well as, for youth, BMI, waist measurement, blood pressure, lipid, and glucose screening.	10%
2) Implement 2-3 interventions for rapid cycle quality improvement with pediatric and adult-serving primary care entities, pharmacies, outpatient behavioral health providers, practice-based care management participants.	20% (2-3 intervention completed)
	10% (1 intervention completed)
3) Provide trainings and/or educational campaign for both PCC Plan and ACO Primary Care providers serving a large number of Covered Individuals prescribed antipsychotics and at impending risk of diabetes.	20%
4) Report and evaluate findings on: <ul style="list-style-type: none"> a. Number of Covered Individuals screened for target interventions b. Year to year comparison of calendar year 2018 verses calendar year 2017 performance on: <ul style="list-style-type: none"> i. SSD HEDIS 2018 measure ii. APM HEDIS 2018 metabolic monitoring rates for youth c. Number of patients in intervention 	10%

groups that had annual follow up monitoring tests as compared to control	
5) Report lessons learned from interventions	10%
6) Plan for improvements to existing quality work plan	5%
7) Discuss findings and opportunities for improvement with participating providers	15%

The maximum payment for this incentive is \$300,000.

Incentive 6. Incentive to Improve Integrated Follow-up for Acute Care Episodes: PCC Authorization, Discharge Notification, and Treatment Plan Transmittal

The Contractor shall hold all Providers of Inpatient BH Covered Services accountable for notifying Primary Care Clinicians and ACO Primary Care Providers for all Covered Individuals discharged from inpatient psychiatric services, and shall support discharging facilities in ensuring timely transmittal of care plans to PCCs as well as specialty BH providers involved in follow-up care.

The Contractor shall provide technical assistance and/or infrastructure support for inpatient psychiatric hospitals in the development and implementation of discharge notification protocols, tools and technologies, including but not limited to:

- Standardization of Operating Procedures,
- Report Formatting,
- Consent Management,
- Workflow Optimization,
- HIE Technology/Use of Mass HIway,
- Tracking and Reporting of Notification and Loop Closure.

The Contractor shall drive implementation of discharge notification and timely transmittal of care plans within all inpatient psychiatric hospitals, including both general and private psychiatric hospital Network Providers for all Covered Individuals.

The Contractor shall produce reporting at the facility level on rates of notification of PCCs for all discharges. For ACO-enrolled Members, the Contractor shall provide the Member's PCP with notices of admission reporting in addition to the reporting on discharges described above.

Incentive Payments associated with successful implementation of discharge notification and, for ACO-enrolled Members, admission reporting, shall be made as follows:

Percent of inpatient psychiatric episodes for which PCC Plan or ACO affiliated Primary Care provider is notified upon discharge as reported to the Contractor by discharging facilities.	40%-74% rate \$200,000	≥75% rate \$300,000
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The maximum payment for this incentive is \$300,000.

**Incentive 7. Incentive to Improve Timely Access to Outpatient Treatment Services:
Open/Technology Enabled Access Solutions**

The Contractor shall support the development of practice redesign and technology enabled solutions to optimize timely and efficient access to outpatient services across the entire network of outpatient providers with whom it is contracted. The Contractor shall develop and implement, whether through centralized procurement, provider incentives, or other provider financing innovations, access solutions that, through practice redesign and use of technology:

- Extend workforce capacity, flexibility, and extensibility
- Reduce slack in the system resulting from no-shows
- Optimize scheduling for same day access.

Within 90 days of contract execution the Contractor shall submit to EOHHS a detailed work-plan itemizing actions and investments to be made in calendar year 2018 to improve timely access to outpatient services, including through adoption of access-enabling technologies.

Incentive payments for successfully cultivating access solutions within the network shall be made as follows:

Percent of Outpatient Providers reporting less than 3 days until next available appointment for urgent care as reported to the Contractor by Outpatient Providers	50%-79% rate \$125,000	≥80% rate \$175,000
Increase Open Access with an additional 10 outpatient provider sites beyond sites added during CY6A	5 provider sites \$75,000	10 provider sites \$125,000

The maximum payment for this incentive is \$300,000.

Incentive 8. Incentive to Support Clinical Design and Network Development for ASAM Level 3.1 Co-occurring Enhanced Services

The Contractor shall facilitate the design of a clinical model and resultant performance specifications for integrated co-occurring enhanced substance use disorder residential treatment services, following the frameworks outlined by the American Society for Addiction Medicine (ASAM) and the Dual Diagnosis Capability in Addiction Treatment (DDCAT). Furthermore, the Contractor shall work with EOHHS on a pricing model that supports the provision of integrated services, inclusive of mental health treatment and addiction pharmacotherapy provided within the context of the Level 3.1 co-occurring enhanced treatment environment. Finally, the Contractor shall engage the provider community and establish a contracted network of licensed providers with a capacity of no less than 60 beds that demonstrated ability to meet the Level 3.1 co-occurring enhanced substance use disorder residential treatment services during the Contract Year.

Within 10 days of execution of this amendment the Contractor shall work with EOHHS to produce a workplan for the design project to encompass the following deliverables, which shall be completed by the end of the Contract Year:

- 2-3 working sessions convening key stakeholders from across EOHHS and other relevant agencies, including the Department of Public Health (DPH) and the Department of Mental Health (DMH)
- Identification and/or development of core components, competencies, and requirements of the clinical model for these services
- Development of detailed performance specifications formalizing requirements and credentialing requirements
- Formal communications with the provider community, including, but not limited to, the issuance of Notice of Intent (NOI)
- Plan for contracting with one or more providers capable of meeting requirements by 9/1/18 or, comparable plan for staging development of clinical capacity amongst current and prospective future providers.
- A contracted network of no less than 60 licensed beds ready to admit Covered Individuals by 1/1/19

Total payments associated with successful completion of these deliverables not to exceed \$550,000.

Incentive 9. Antidepressant Medication Management (HEDIS measure: AMM)

Goal Statement: In calendar year 2018, the Contractor shall measure and report the rate for antidepressant medication management using the HEDIS AMM 2018 technical specifications. The Contractor shall continue to demonstrate that care integration and Member Engagement will improve the rate at which Enrollees, who had been newly diagnosed with depression, and started on antidepressant medication, remain on the medication for an effective course of treatment.

- The interventions will support behavioral health and medical integration as both delivery systems serve Covered Individuals on antidepressant medication.
- The interventions will support access to evidence-based, integrated primary care among clients with diagnosed depression as measured by the HEDIS 2018 Antidepressant Medication Management Measure.
- The interventions will support improvement in depression management and continuity of care among clients who receive care for depression in specialty behavioral health settings.

Deliverables: By December 31, 2018, the Contractor shall:

- 1) Identify all Covered Individuals receiving antidepressant medication with HEDIS-based gaps in care.
- 2) Design and deliver 2-3 interventions implemented for rapid cycle quality improvement involving primary care entities, pharmacies, outpatient behavioral health providers, and/or practice-based care management participants.
- 3) Leverage existing network management infrastructure for direct work with PCC Plan providers, outpatient behavioral health, or other entities as appropriate to implement QI opportunities.
- 4) Within 90 days of contract execution the Contractor shall produce a proposed plan and calendar of events for training(s) and educational activities. Provide training(s) and/or educational campaign(s) for both PCC Plan and ACO Primary Care providers serving a large number of Covered Individuals prescribed antidepressant medication to support the Chronic Care Model for depression or other evidence-based practices for management of depression in primary care.

Within ninety (90) days of end of Contract Year, the Contractor shall:

- 1) Report and evaluate findings on:
 - a. Number of Members identified with gaps in care
 - b. Number of Members targeted for intervention as part of QI initiative implementation
 - c. Number of patients in intervention groups whose HEDIS 2018 rates improved compared to those not in the intervention groups
- 2) Report lessons learned from interventions
- 3) Plan for improvements to existing quality work plan
- 4) Discuss findings and opportunities for improvement with participating providers
- 5) Report year over year improvement between calendar year 2018 performance and HEDIS 1/1/2017 – 12/31/2017

The maximum payment for this incentive is \$200,000.

Percent of maximum payment will be distributed as follows:

1) Identify all Covered Individuals receiving antidepressant medication with HEDIS-based gaps in care.	10%
2) Design and deliver 2-3 interventions implemented for rapid cycle quality improvement involving primary care entities, pharmacies, outpatient behavioral health providers, and/or practice-based care management participants. <ul style="list-style-type: none"> Leverage existing network management infrastructure for direct work with PCC, outpatient behavioral health, or other entities as appropriate to implement QI opportunities. 	25% (2 interventions completed)
	15% (1 additional intervention completed)
3) Report and evaluate findings on: <ol style="list-style-type: none"> Number of Members identified with gaps in care Number of Members targeted for intervention as part of QI initiative implementation Number of patients in intervention groups whose HEDIS rates improved 	10%
4) Report lessons learned from interventions and develop plan for improvements to existing quality work plan	5%
5) Provide training(s) and/or educational campaign(s) for both PCC Plan and ACO Primary Care providers serving a large number of Covered Individuals prescribed antidepressant medication to support the Chronic Care Model for depression or other evidence-based practices for management of depression in primary care.	10%
6) Discuss findings and opportunities for improvement with participating providers	15%
7) Report year over year improvement between calendar year 2018 performance and HEDIS 1/1/2017 – 12/31/2017	10%

Incentive 10. Development and Validation of New Measures (Pay for Reporting)

Goal Statement:

1. In calendar year 2018, the Contractor shall report baseline measurement on new HEDIS and HEDIS-derived measures related to continuity and coordination of care for Covered Individuals experiencing acute episodes of behavioral health care. The Contractor shall report performance on these measures for calendar years 2017 and 2018 so as to establish a sufficiently robust baseline. The Contractor shall complete all activities necessary to collect, measure, and validate reporting on these metrics during calendar year 2018.
2. The Contractor shall collaborate with EOHHS on the development and refinement of these new measures for reporting as well as the form and frequency of reporting going forward.

Measures for Reporting shall include the following measures and technical specifications:

New Measure	Description	Specification	Incentive	Maximum Payout
Follow-up after ED for MH (FUM)	<p>The percentage of emergency department (ED) visits for Covered Individuals 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:</p> <p>1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.</p> <p>2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.</p> <p>3. Each of the above rates excluding ESP encounters</p>	<p>1-2. HEDIS 2018 Measure Specification for FUM</p> <p>3.HEDIS Numerator Minus ESP Visits</p>	Reporting	\$125,000

Follow-up after ED for Alcohol or Other Drug Abuse or Dependence	<p>The percentage of emergency department (ED) visits for Covered Individuals 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:</p> <p>1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.</p> <p>2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.</p>	HEDIS 2018 Measure Specification for FUA	Reporting	\$125,000
Med Mgmt FUH	Rates of follow-up Medication Management Visits within 7 and 30 days of Inpatient Psychiatric Hospitalization	HEDIS FUH Denominator; Numerator Counting Medication Management Visits Only	Reporting	\$125,000
PCC FUH	Rates of Follow-up Primary Care Visits within 7 and 30 Days of Inpatient Psychiatric Hospitalization	HEDIS FUH Denominator; Numerator Counting PCC visit within 7 and 30 days	Reporting	\$125,000

The maximum payment for this incentive is \$500,000

Incentive 11. Reduction in the Hospital Emergency Department (ED) Boarding

Goal Statement

1. In calendar year 2018 the Contractor shall demonstrate an average weekly rate of ED boarders no greater than the average achieved from 1/1/2017 to 12/31/2017.
2. In calendar year 2018 the contractor shall maintain or reduce the average length of stay for ED boarders relative to the ALOS from 1/1/2017 to 12/31/2017.
3. For Calendar year 2018 and calendar year 2017 achievement results for this measure shall represent the months March through December (ten months) for each year. The contractor shall also track and measure results for 2018 (twelve months).

For M1, the Contractor shall report on a year over year comparison of the average weekly ED boarders in calendar year 2017 to the average weekly ED boarders in calendar year 2018

For M2, the Contractor shall report on a year over year comparison of the ALOS of ED boarders in calendar year 2017 to the ALOS of ED boarders in calendar year 2018.

New Measure	Description	Specification	Incentive	Maximum Payout
M1- No. of Boarders	Reduce the average weekly ED boarders	Determine the average weekly ED boarders in calendar year 2017 and calendar year 2018	Maintain average weekly boarders in calendar year 2018 of no more than average weekly boarders achieved in calendar year 2017.	\$125,000
M2-ALOS	Reduce ALOS for ED Boarding	Compare the 2017 ALOS for ED Boarding to 2018.	Maintain an ALOS for boarders in calendar year 2018 of no more than the ALOS achieved in calendar year 2017.	\$125,000

Maximum payout is \$250,000

Incentive 12. Program to Support a Practice-Based Care Management System

Goal Statement: A goal of the Care Management Program is to support the transition of Enrollees into Practice-Based Care Management programs delivering quality care management services for Enrollees assigned to their practice. The Contractor shall support this effort by establishing an incentive program for providers aimed at rewarding Providers for successfully engaging clients in practice-based care management. Within forty-five (45) days of the execution of this amendment, the Contractor shall submit for EOHHS review and approval a plan for CY18 that will provide an enhanced fee for new admissions to the Practice-Based Care Management Program and a fee for monthly ongoing care management. This payment applies to Practice-Based Care Management provided from January 1, 2018 to December 31, 2018.

Subject to EOHHS's approval of the Contractor's plan and the Contractor's successful implementation of the incentive program, the maximum incentive payment for this Outcome measure is \$150,000.

APPENDIX H-1

PAYMENT AND RISK SHARING PROVISIONS

Capitation Rates for Contract Year 2018: January 1, 2018, through December 31, 2018, and separate contract rate periods:
 January 1, 2018, through February 28, 2018 (CY18A),
 January 1, 2018, through March 31, 2018 (CY18MFP), and
 March 1, 2018, through December 31, 2018 (CY18B)

Section 1. MassHealth Capitation Payment

A. Per-Member Per-Month (PMPM) and Per member Per-day (PMPD) Capitation Rates for Contract (pursuant to Section 10.2 of the Contract)

PMPM and PMPD Service and Administrative Capitation Rates

1. Contract Period CY18A – January 1, 2018, to February 28, 2018

a. PCC & TPL Capitation Rates (CY18A)

Rating Category:	Medical Services PMPM	Medical Services PMPD	CBHI-ADD-ON PMPM	CBHI-ADD-ON PMPD	ABA-ADD-ON PMPM	ABA-ADD-ON PMPD	Admin PMPM	ADMIN PMPD	Total PMPM	Total PMPD
Rating Category I Child	28.73	0.94	33.34	1.10	2.69	0.09	4.43	0.15	69.19	2.28
Rating Category 1 Adult	36.25	1.19					4.54	0.15	40.79	1.34
Blended RC1	30.78	1.01	24.23	0.80	1.96	0.06	4.46	0.15	61.43	2.02
Rating Category I TPL	4.99	0.16	32.05	1.06	1.93	0.06	4.07	0.13	43.04	1.41
Rating Category II Child	139.15	4.57	175.34	5.76	44.57	1.47	10.84	0.36	369.90	12.16
Rating Category II Adult	187.06	6.15					11.56	0.38	198.62	6.53
Blended RCII	174.78	5.75	44.96	1.48	11.43	0.38	11.38	0.37	242.55	7.98
Rating Category II TPL	15.23	0.51	104.58	3.44	18.69	0.61	8.95	0.29	147.45	4.85
Rating Category IX	65.13						4.98		70.11	
Rating Category X	287.36						13.09		300.45	

2. Contract Period CY18B - March 1, 2018, to December 31, 2018

a. PCC and TPL: PMPM (\$) Rates (CY18B)

Rating Category	Medical Services PMPM	CBHI PMPM	ABA PMPM	SUD PMPM	Admin PMPM	Total PMPM
Rating Category I Child	40.48	42.01	2.16	0.08	5.21	89.94
Rating Category I Adult	40.49			1.48	4.67	46.64
Rating Category I TPL	4.77	32.43	2.63	0.01	4.52	44.36
Rating Category II Child	135.50	154.72	43.58	0.18	12.18	346.16
Rating Category II Adult	186.53			2.62	10.85	200.00
Rating Category II TPL	14.59	104.89	26.24	0.06	9.07	154.85
Rating Category IX	70.33			4.74	5.12	80.19
Rating Category X	339.11			15.07	13.11	367.29

b. Primary Care ACO: PMPM (\$) Rates (CY18B)

Rating Category	Medical Services PMPM	CBHI PMPM	ABA PMPM	SUD PMPM	Admin PMPM	Total PMPM
Rating Category I Child	19.19	23.79	2.16	0.08	3.77	48.99
Rating Category I Adult	42.20			1.48	3.85	47.53
Rating Category II Child	113.40	163.03	43.58	0.18	10.31	330.50
Rating Category II Adult	196.04			2.62	10.75	209.41
Rating Category IX	70.94			4.74	4.23	79.91
Rating Category X	342.51			15.07	12.63	370.21

c. Contract Period CY18MFP - PMPM (\$) Rates (January 1, 2018, to March 31, 2018)

Rating Category	Medical Services PMPM	Admin PMPM	Total PMPM
MFP	81.18	5.03	86.21

B. Risk Sharing Corridors for Contract Period CY18B, for the Medical Services rates Component of Rating Categories Child I, Adult I, Child II, Adult II, I-TPL, II-TPL, IX, and X (pursuant to Section 10.6 of the Contract) for PCC and TPL programs

1. Gain on the Medical Services Capitation Rates excluding CBHI, ABA and SUD services

The amount of the Gain on the aggregate Medical Services Capitation Rates for the Contract shall be defined as the difference between the Total medical services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are less than the Total Medical Services Capitation Payment for Contract Year 2018. EOHHS and the Contractor shall share such gain in accordance with the table below.

Gain	MassHealth Share	MBHP Share
Between 0 and 2%	0%	100%
>2%	100%	0%

2. Loss on the Medical Services Capitation Rates excluding CBHI, ABA and SUD services

The amount of the Loss on the aggregate Medical Services Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are greater than the Total Medical Services Capitation Payment for Contract Year 2018. EOHHS and the Contractor shall share such loss in accordance with the table below.

Loss	MassHealth Share	Contractor Share
Between 0 and 2%	0%	100%
>2%	100%	0%

C. Risk Sharing Corridors for CY18B for the Medical Services rates Component of Rating Categories Child I, Adult I, Child II, Adult II, IX, and X (pursuant to Section 10.6 of the Contract) for the Primary Care ACO program,

1. Gain on the Medical Services Capitation Rates excluding CBHI, ABA and SUD services

The amount of the Gain on the aggregate Medical Services Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are less than the Total Medical Services Capitation Payment for the CY18B. EOHHS and the Contractor shall share such gain in accordance with the table below.

Gain	MassHealth Share	MBHP Share
Between 0 and \$100,000	99%	1%
>\$100,000	100%	0%

2. Loss on Medical Services Capitation Rates excluding CBHI, ABA and SUD services

The amount of the Loss on the Capitation Rates for the Contract shall be defined as the difference between the Total Medical Services Capitation Payment and the Contractor's Total Expenditures for Covered Services, if such actual expenditures are greater than the Total Medical Services Capitation Payment for the CY18B. EOHHS and the Contractor shall share such loss in accordance with the table below.

Loss	MassHealth Share	Contractor Share
Between 0 and \$100,000	99%	1%
>\$100,000	100%	0%

D. Risk Sharing Corridors for Contract Year 2018 effective January 1, 2018, through December 31, 2018, for CBHI, ABA and SUD Services for PCC, TPL and Primary Care ACO programs:

The Contractor and EOHHS shall share risk for CBHI, ABA and SUD Services in accordance with the following provisions:

1. For Contract Year 2018, EOHHS shall conduct separate reconciliations with respect to CBHI, ABA and SUD Services, as follows:
 - a. EOHHS will first determine the amount paid to the Contractor by EOHHS for CBHI, ABA and SUD Services for Contract Year 2018, by multiplying the following:
 - i. The CBHI, ABA and SUD Add-On rates determined by EOHHS and provided to the Contractor in **Section 1.A** above; by
 - ii. The number of applicable member months for the period.
 - iii. For purposes of the 2018 reconciliations, ABA and CBHI Services are effective January 1, 2018, and SUD Services are effective March 1, 2018.
 - b. EOHHS will then determine the Contractor's expenditures for CBHI, ABA and SUD Services for Contract Year 2018, using claims data submitted in the report described in **Section D.2** below and Encounter Data submitted by the Contractor.
- If the amount paid to the Contractor, as determined by the calculation described in Section C.1.a above, is greater than the Contractor's expenditures, as determined by the calculation described in Section C.1.b above, then the Contractor shall be considered to have experienced a gain with

respect to CBHI, ABA and SUD Services for Contract Year 2018. EOHHS and the Contractor shall share such gain in accordance with the table below for CBHI, ABA, and SUD services:

Gain	MassHealth Share	Contractor Share
Between \$0 and \$100,000	99%	1%
> \$100,000	100%	0%

If the amount paid to the Contractor, as determined by the calculation described in **Section C.1.a** above, is less than the Contractor's expenditures, as determined by the calculation described in **Section C.1.b.** above, then the Contractor shall be considered to have experienced a loss with respect to CBHI, ABA and SUD Services for Contract Year 2018. EOHHS and the Contractor shall share such loss in accordance with the table below:

Loss	MassHealth Share	Contractor Share
Between \$0 and \$100,000	99%	1%
> \$100,000	100%	0%

2. To assist with the reconciliation process for CBHI, ABA and SUD Services described above, the Contractor shall, within 180 days after the end of Contract Year 2018, submit claims data with respect to CBHI, ABA and SUD services in the form and formats specified in **Appendix E**.

E. Risk Sharing Corridors for CY18MFP for the Service Component of Rating Category VIII MFP (pursuant to Section 10.6 of the Contract)

1. Gain on the services component of MFP Capitation Rates

The amount of the Gain on the aggregate PMPM Capitation Rates for Rating Category VIII MFP shall be defined as the difference between the Total services PMPM Capitation Payment and the Contractor's Total Expenditures for Covered Services for Rating Category VIII, if such actual expenditures are less than the Total services PMPM Capitation Payment for Rating Category VIII for the CY18MFP. EOHHS and the Contractor shall share such gain in accordance with the table below:

Gain	MassHealth Share	Contractor Share
Gain up to \$50,000	99%	1%
Gain of more than \$50,000	100%	0%

2. Loss on the Services component of MFP Capitation Rates

The amount of the Loss on the aggregate PMPM Capitation Rates for Rating Category VIII MFP shall be defined as the difference between the Total services PMPM Capitation Payment and the Contractor's Total Expenditures for Covered Services for Rating Category VIII, if such actual expenditures are greater than the Total services PMPM Capitation Payment for Rating Category VIII for the CY18MFP. EOHHS and the Contractor shall share such loss in accordance with the table below:

Loss	MassHealth Share	Contractor Share
Loss up to \$50,000	99%	1%
Loss of more than \$50,000	100%	0%

Section 2. MassHealth Other Payments

A. Care Management Program

The Contractor shall calculate and report on the number of engaged enrollees in the Practice Based Care Management program (PBCM) on a monthly basis and shall be paid an Engagement PPPM, upon EOHHS review and approval, on a quarterly basis.

Base Per-Participant Per-Month (PPPM) Rate for Practice Based Care Management Contract.

Engagement:

Per Participant Per Month.....\$175.00

B. Performance Incentives Arrangements

Total Performance Incentive Payments detailed in appendix G, may not exceed 105 percent of approved Capitation Payments attributable to the Covered Individuals or services covered by the Contract.

The Performance Incentive Payments for Contract Year 2018 will be a total of 4,150,000.

C. PCC Plan Management Support

Base Per-Member (Enrollees) Rate for PCC Plan Management Support.

Per Participant Per Month.....\$1.25

Per Participant Per Day.....\$0.041

D. Supplemental specialized inpatient psychiatric services per diem rate

EOHHS shall make supplemental per diem rate payment of \$600 for specialized psychiatric inpatient claims as specified in **Section 4.12** and **Section 10** of the Contract. To assist with this payment processing, the Contractor shall provide claims data on quarterly basis in a format and at a frequency to be specified by EOHHS in **Appendix E**.

Section 3. DMH Compensation Payments (Non-MassHealth Payments)

A. DMH Payments for the Contract (pursuant to Section 10.9 of the Contract)

The total Contract Year 2018 DMH Compensation Payment for the Specialty Programs through December 31, 2018, shall be \$10,737,388.00, as described in Sections 3.B-3.E below.

B. DMH ESP Program for Uninsured Individuals Service Compensation Rate Payment (pursuant to Sections 3.4, 10.9 and 10.10 of the Contract)

The DMH ESP Program for Uninsured Individuals Service Compensation Rate Payment shall consist of the following amounts:

1. The Contract Year 2018 amount shall be \$8,680,000.
2. The monthly payment shall be \$723,333.33.

C. DMH ESP expansion -- Safety initiatives:

1. The DMH ESP safety initiative payment shall be \$1,403,388 for Contract Year 2018.
2. The monthly payment amount shall be \$116,949.00.

D. DMH Specialty Program Administrative Compensation Rate Payment (pursuant to Section 10.9.A of the Contract)

The DMH Specialty Program Administrative Compensation Rate Payment shall be \$424,000 for Contract Year 2018.

1. Indirect Costs shall not exceed 3.5% of Direct Costs.
2. The total of Direct Costs plus Indirect Costs shall not exceed \$397,749.
3. Earnings shall be 6.6% of the total direct and indirect costs.
4. Earnings shall be \$26,251 for Contract Year 2018.
5. The amount of the monthly DMH Specialty Program Administrative Compensation Rate Payment shall be \$35,333.33.

E. DMH Payments for Forensic Services and other Forensic Evaluations (pursuant to Sections 4.6 and 10.9.B of the Contract)

1. The Forensic Evaluations (known as “18(a)”) amount for the Contract Year 2018 shall be \$230,000. EOHHS will issue this amount as one-time payment during the contract period.
2. The Contractor shall return to EOHHS any portion of the DMH Payments for Forensics Services amount that it does not spend on Forensic Evaluations as identified in the annual reconciliation of the Contract Year 2018 within 60 days of the identification of such under spending unless otherwise agreed to by the parties.

F. Massachusetts Child Psychiatric Access Project (pursuant to Section 10.9.A of the Contract)

1. The DMH Payment for MCPAP services for Contract Year 2018 shall be \$3,600,000.
 - a. The monthly payment for the DMH Payment for MCPAP shall be \$300,000.00.
2. The DMH payment for MCPAP administrative compensation for Contract Year 2018 shall be \$185,000.
 - a. The amount of the monthly DMH MCPAP Program Administrative Compensation Rate Payment shall be \$15,416.67.
 - b. Indirect Costs shall not exceed 3.5% of Direct Costs.
 - c. The total of Direct Costs plus Indirect Costs shall not exceed \$173,546.
 - d. Earnings shall be 6.6% of the total direct and indirect costs.
 - e. Earnings shall be \$11,454 for the Contract Year 2018.
3. The Contractor shall return to EOHHS any portion of the DMH Payment for MCPAP that it does not spend on the MCPAP identified in the annual reconciliation for Contract Year 2018, within 60 days of the identification of such unspent portion unless otherwise agreed to by the parties.

Section 4: Other Non-MassHealth Payments

A. ESP Opioid Overdose Response Pilot Program

Contingent upon receipt of funds from The Department of Public Health (DPH), EOHHS will make a payment to the contractor for the ESP Opioid Overdose Response Pilot Program for Contract Year 2018 in the amount of \$358,000. The Contractor shall return to EOHHS any portion of the DPH payment for ESP Opioid Overdose Response Pilot program that it does not spend on the Pilot identified in the annual reconciliation for Contract Year 2018, within 60 days of the identification of such unspent portion unless otherwise agreed to by the parties.

**B. DCF -Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP)
Payment Provisions**

Contingent upon receipt of funding from DCF, EOHHS shall pay the Contractor \$5,000 for each of the Contractor's Emergency Services Programs that contract with the Contractor to operate the MCI/RAP in accordance with **Section 4.9** for Contract Year 2018.

**C. DCF-Massachusetts Child/Adolescent assessment Protocol (MCAAP) Payment
Provisions**

Contingent upon receipt of funding from DCF, EOHHS shall pay the Contractor \$7,500 in Contract Year 2018 for training and implementation of the MCAAP evaluation process.