COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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

CONTRACTOR LEGAL NAME: Boston Medical Center Health Plan, Inc. **(and d/b/a):** Boston Medical Center HealthNet Plan	**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS
Legal Address: (W-9, W-4): 529 Main St., Ste. 500, Charlestown, MA, 02129	**Business Mailing Address:** One Ashburton Place, 11th Floor, Boston, MA 02108
Contract Manager: Nelie Lawless **Phone:** 617-791-9346	**Billing Address (if different):**
E-Mail: Nelie.Lawless@BMCHP-wellsense.org **Fax:**	**Contract Manager:** Derek Tymon **Phone:** 617-847-6587
Contractor Vendor Code: VC7000072388	**E-Mail:** Derek.Tymon@mass.gov **Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**	**MMARS Doc ID(s):** N/A **RFR/Procurement or Other ID Number:** BD-17-1039-EHS01-EHS01-10209

☐ **NEW CONTRACT**	☒ **CONTRACT AMENDMENT**
PROCUREMENT OR EXCEPTION TYPE: (Check one option only) ☐ **Statewide Contract** (OSD or an OSD-designated Department) ☐ **Collective Purchase** (Attach OSD approval, scope, budget) ☐ **Department Procurement** (includes all Grants - 815 CMR 2.00) (Solicitation Notice or RFR, and Response or other procurement supporting documentation) ☐ **Emergency Contract** (Attach justification for emergency, scope, budget) ☐ **Contract Employee** (Attach Employment Status Form, scope, budget) ☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope and budget)	Enter **Current Contract End Date *Prior*** to Amendment: **December 31, 2022.** Enter **Amendment Amount**: $ no change. (or "no change") **AMENDMENT TYPE: (Check one option only. Attach details of amendment changes.)** ☒ **Amendment to Date, Scope or Budget** (Attach updated scope and budget) ☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget) ☐ **Contract Employee** (Attach any updates to scope or budget) ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

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

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

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

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)

This **Amendment 2 to the Third Amended and Restated MCO Contract** with Boston Medical Center HealthNet Plan revises rate and policy provisions, as well as updates appendices.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:
☐ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.
☒ 2. may be incurred as of **January 1, 2021**, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.
☐ 3. were incurred as of ______, **20__**, a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **December 31, 2022,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

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

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:	AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:
X: [signature] Date: April 13, 2021	X: [signature] Date: 4/18/21
(Signature and Date Must Be Handwritten At Time of Signature)	(Signature and Date Must Be Handwritten At Time of Signature)
Print Name: Ellen Weinstein	Print Name: Daniel Tsai
Print Title: Chief Legal Officer	Print Title: Assistant Secretary for MassHealth

AMENDMENT #2

TO THE

THIRD AMENDED AND RESTATED

MASSHEALTH MANAGED CARE ORGANIZATION CONTRACT

WITH

BOSTON MEDICAL CENTER HEALTH PLAN, INC.

WHEREAS, the Executive Office of Health and Human Services ("EOHHS") and Boston Medical Center Health Plan, Inc. ("Contractor") entered into the Contract effective October 2, 2017, and with an Operational Start Date of March 1, 2018, to make available high quality, coordinated, comprehensive health care services on a capitated basis to specific eligible groups; and

WHEREAS, EOHHS and the Contractor amended and restated the Contract effective January 1, 2021, (the Third Amended and Restated Managed Care Organization Contract), and further amended the Contract through Amendment #1;

WHEREAS, in accordance with **Section 5.8** of the Contract, EOHHS and the Contractor desire to amend the Contract effective January 1, 2021; and

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

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

1. **Section 2, Contractor Responsibilities,** is hereby amended by adding at the end of **Section 2.7.D.7** a new **Section 2.7.D.7.l:**

   "l. For Behavioral Health Screening screens specified by EOHHS, the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 317, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services."

2. **Section 2, Contractor Responsibilities,** is hereby amended by adding a new **Section 2.7.D.11** and **Section 2.7.D.12** as follows**:**

   "11. For COVID-19 vaccine administration, the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 446, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

12. For monoclonal antibody product infusion, the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 446, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services."

3. **Section 2, Contractor Responsibilities**, is hereby amended by inserting the following new **Section 2.22.B.3** and renumbering the subsequent subsections accordingly**:**

"3. Inpatient Hospitals Accepting COVID-Positive MassHealth Members for Inpatient Mental Health Services

The Contractor shall increase payment rates to DMH-licensed psychiatric hospitals and all units with DMH-licensed beds within applicable acute inpatient hospitals (AIHs) or chronic disease rehabilitation hospitals (CDRHs) (collectively, "hospitals") identified by EOHHS as having received Tier 1 or Tier 2 designation by DMH in accordance with DMH bulletin #20-05R and having met any other DMH requirements for eligibility.

a. The Contractor shall increase its rates in accordance with this section for dates of service from January 1, 2021, through 30 days following the expiration of the Governor's March 10, 2020, Declaration of a State of Emergency within the Commonwealth due to the COVID-19 pandemic.

b. For hospitals described in this section that have admitted COVID-19-positive Enrollees for inpatient mental health services, the Contractor shall apply a $1,050 per diem absolute increase to its current contracted rate for up to the first 14 days of an Enrollee's stay. This $1,050 per diem increase applies for those dates of service on which a hospital described in this section provides inpatient mental health services or administratively necessary day services immediately following inpatient mental health services provided to an Enrollee.

1) The Contractor shall apply this rate increase for Tier 2 hospitals described above when:

a) The hospital admitted the Enrollee into a DMH-licensed bed for the primary purpose of rendering inpatient mental health services;

b) The Enrollee is confirmed to have been positive for COVID-19 at the time of admission to the DMH-licensed bed based on a COVID-19 molecular diagnostic test or an FDA-approved rapid antigen test administered before admission or within 96 hours after admission; and

c) The Enrollee is not suspected to have become COVID-19-positive from exposure occurring within the admitting hospital or from interactions with any member of the hospital's staff or other currently COVID-19-positive patients at the hospital.

2) The Contractor shall apply this rate increase for Tier 1 hospitals described above when:

a) The hospital admitted the Enrollee into a DMH-licensed bed for the primary purpose of rendering inpatient mental health services;

b) The Enrollee was admitted with negative or pending COVID-19 test results, and is later confirmed to be positive for COVID-19 based on a COVID-19 molecular diagnostic test or an FDA-approved rapid antigen test administered before admission or within 96 hours after admission;

c) The Enrollee is not suspected to have become COVID-19-positive from exposure occurring within the admitting hospital or from interactions with any member of the hospital's staff or other currently COVID-positive patients at the hospital; and

d) The hospital was unable to transfer the Enrollee to a designated Tier 2 hospital."

4. **Section 4, Payment and Financial Provisions,** is hereby amended by deleting **Section 4.2.G** in its entirety and replacing it with a new **Section 4.2.G** as follows:

"G. Coverage of Newborns

1. If a newborn became an Enrollee prior to January 1, 2021, EOHHS shall enroll and retrospectively pay the Risk Adjusted Capitation Rate for a newborn effective on the newborn's date of birth provided that:

a. The mother was an Enrollee in the Contractor's MassHealth plan at the time of the birth;

b. The Notification of Birth (NOB) form was submitted by the hospital in accordance with **Section 2.4.C.2.;** and

c. The Contractor is in compliance with the other provisions of **Section 2.4.C**.

2. If a newborn becomes an Enrollee on or after January 1, 2021, EOHHS shall prospectively pay a Risk Adjusted Capitation Rate for the newborn as of the newborn's Effective Date of Enrollment."

5. **Appendix A**, **MCO Reporting Requirements**, is hereby deleted in its entirety and replaced with a new **Appendix A** attached hereto.

6. **Appendix B, Quality Improvement Goals**, is hereby deleted in its entirety and replaced with a new **Appendix B** attached hereto.

7. **Appendix C, Exhibit 4, MassHealth Excluded Services – All Coverage Types** is hereby amended by deleting Section 6.c in its entirety.
8. **Appendix P, MCO-Administered ACO Contract Specifications**, is hereby deleted in its entirety and replaced with a new **Appendix P** attached hereto.
9. **Appendix T, Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule,** is hereby deleted in its entirety and replaced with a new **Appendix T** hereto.
10. **Appendix W**, **Special Kids Special Care (SKSC) Program**, is hereby amended by deleting the second paragraph in its entirety and replacing it with the following:

    "Effective January 1, 2019, the directed payment specified in **Section 2.7.D.6** of the MCO Contract shall not apply when serving Enrollees in the SKSC Program. Effective January 1, 2020, the "Acute Hospital Services" and "Acute Hospital Services – DRG Specific" directed payments specified in **Section 2.22.C** and **Appendix Z** of the MCO Contract shall not apply when serving Enrollees in the SKSC Program."

11. **Appendix Z**, **Directed Payments Related to COVID-19 (2020)**, is hereby deleted in its entirety and replaced with a new **Appendix Z** attached hereto. The Table of Contents is also hereby amended to reflect the new name of Appendix Z.

APPENDIX A
MCO REPORTING REQUIREMENTS

This Appendix summarizes the reporting requirements described in the Contract. EOHHS may update these requirements from time to time. The Contractor shall submit corresponding Certification Checklists of all reports/submissions listed in **Appendix A** within the timelines specified herein. The Contractor may include a narrative summary to reports/submissions and may include graphs that explain and highlight key trends. All reports must be submitted via OnBase, the EOHHS Contract Management system, unless otherwise indicated below in the *"Target System"* column. Numbering sequence and Report Title that will appear in the OnBase system can be found in **BOLD** in the *"Name of Report"* column.

For all of the reports listed below, unless otherwise specified, if the Contractor meets the target for a given report, the Contractor shall only complete a short narrative description on the report cover sheet. For any report that indicates that the Contractor is not meeting the target, the Contractor shall submit a detailed narrative that includes the results, an explanation as to why the Contractor did not meet the target, and the steps the Contractor is taking to improve performance going forward.

The Contractor shall provide all Reports in the form and format required by EOHHS and shall participate with EOHHS in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate. Targets shall be changed to reflect improvement in standards over time.

All exhibits referenced herein pertain to **Appendix A**, unless otherwise noted. Such exhibits set forth the form and format the Contractor shall use for each report below. These exhibits shall be provided to the Contractor and may be updated by EOHHS from time to time. EOHHS shall notify the Contractor of any updates to the exhibits.

Reporting Deliverable Schedule

1. **Same Day Notification (Immediate Notice Upon Discovery):** Deliverables due the same day as discovery. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.
2. **Next Day Notifications:** Deliverables due the next day. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.
3. **Two Business Days Notification:** Deliverables due in two business days
4. **Weekly Deliverables:** Deliverables due by close of business/COB on Fridays
5. **Within 7 Calendar Days of Occurrence Notification:** Deliverables due within seven calendar days of occurrence. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due within 7 calendar days of the next business day.
6. **No later than 30 days prior to execution:** Deliverables due thirty days prior to implementation for review and approval by EOHHS.
7. **Monthly Deliverables:** Deliverables due on a monthly basis, by the last day of the month, following the month included in the data, unless otherwise specified by EOHHS.
8. **Quarterly Deliverables:** Deliverables due on a contract year (CY) quarterly basis, by the last business day of the month following the end of each quarter, unless otherwise specified.

   CY Quarter 1: January 1 – March 31

   CY Quarter 2: April 1 - June 30

   CY Quarter 3: July 1 – September 30

   CY Quarter 4: October 1 – December 31
9. **Semi-Annual Deliverables:** Deliverables due by the last business day of the month following the end of the reporting period, unless otherwise specified. The semi-annual reporting periods are as follows:

   January 1 – June 30

   July 1 – December 31
10. **Annual Deliverables**: Deliverables due by the last business day of the month following the end of the reporting period (Contract Year: January 1 -- December 31), unless otherwise specified by EOHHS.
11. **Ad-Hoc Deliverables**: Deliverables are due whenever the Contractor has relevant changes or information to report, or upon EOHHS request related to Behavioral Health, Contract Management, Financial, Quality, Pharmacy, and Operations deliverables as applicable.

A. Report and Compliance Certification Checklist: Exhibit C-1

Annually - The Contractor shall list, *check off,* sign and submit a Certification of Data Accuracy for all Contract Management (also including Coordination of Benefits, Hospital Utilization, Fraud and Abuse, Encounter Data and Drug Rebate claims data), Behavioral Health, Financial, Operations and Quality reports/submissions, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of the Contractor's knowledge, information and belief, after reasonable inquiry. For each report in the sections below, if an attestation is required with the submission, that information will be included within the reporting template.

B. Contract Management Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-03	**CM-03 Member Telephone Statistics** Member Telephone Statistics	Monthly	OnBase
CM-04	**CM-04 Member Education and Related Orientation, Outreach Materials** Member Education and Related Orientation, Outreach Materials (including enrollment materials for MH Customer Service Center (CSC)	Ad-Hoc	OnBase
CM-05	**CM-05 Updated Provider Directory** Provider Directory	Ad-Hoc	OnBase
CM-06	**CM-06 Provider Manual** Provider Manual	Ad-Hoc	OnBase
CM-07	**CM-07 Marketing Materials** Marketing Materials *(60 days in advance of use, including materials to be distributed at Contractor and non-Contractor sponsored health fairs or community events)*	Ad-Hoc	OnBase
CM-08	**CM-08 Marketing Materials- Annual Executive Summary** Marketing Materials- Annual Executive Summary (including a written statement that all of the Contractor's marketing plans and materials are accurate and do not mislead, confuse, or defraud Members or the state)	Annual	OnBase
CM-09	**CM-09 Significant Changes in Provider Network Notification** Significant Changes in Provider Network Notification. (Notification: Same Day)	Ad-Hoc	OnBase
CM-10-A	**CM-10-A Summary of A&A: Ensuring Enrollees access to Medically Necessary services** Summary of Access and Availability: Description of Ensuring	Annual	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Enrollees have access to Medically Necessary services		
CM-10-A-ADH	**CM-10-A-ADH Summary of A&A: Ensuring Enrollees access to Medically Necessary Services** Summary of Access and Availability: Description of Ensuring Enrollees have access to Medically Necessary services	Ad-Hoc	OnBase
CM-10-B	**CM-10-B Summary of A&A: Summary of Significant Changes in Provider Network** Summary of Access and Availability: Summary of Significant Changes in Provider Network	Annual	OnBase
CM-10-B-ADH	**CM-10-B-ADH Summary of A&A: Summary of Significant Changes in Provider Network** Summary of Access and Availability: Summary	Ad-Hoc	OnBase
CM-10-C	**CM-10-C PCP and Specialty Accessibility Report** PCP and Specialty Accessibility Report	Annual	OnBase
CM-10-C-ADH	**CM-10-C-ADH PCP and Specialty Accessibility Report** PCP and Specialty Accessibility Report	Ad-Hoc	OnBase
CM-10-D1	**CM-10-D1 Summary of A&A: Geographic Access Report for Adult PCPs** Summary of Access and Availability: Geographic Access Report for Adult PCPs. (demonstrating access by geography)	Annual	OnBase
CM-10-D1-ADH	**CM-10-D1-ADH Summary of A&A: Geographic Access Report for Adult PCPs** Summary of Access and Availability: Geographic Access Report for Adult PCPs (demonstrating access by geography)	Ad-Hoc	OnBase
CM-10-D2	**CM-10-D2 Summary of A&A: Geographic Access Report for Pediatric PCPs** Summary of Access and Availability: Geographic Access Report for Pediatric PCPs) (demonstrating access by geography)	Annual	OnBase
CM-10-D2-ADH	**CM-10-D2-ADH Summary of A&A: Geographic Access Report for Pediatric PCPs** Summary for Access and Availability: Geographic Access Report for Pediatric PCPs (demonstrating access by geography)	Ad-Hoc	OnBase
CM-10-D3	**CM-10-D3 Summary of A&A: Geographic Access Report for Acute inpatient hospitals** Summary of Access and Availability: Geographic Access Report for Acute inpatient hospitals (demonstrating access by geography)	Annual	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-10-D3-ADH	**CM-10-D3-ADH Summary of A&A: Geographic Access Report for Acute inpatient hospitals** Summary of Access and Availability: Geographic Access Report for Acute Inpatient hospitals (demonstrating access by geography)	Ad-Hoc	OnBase
CM-10-E1	**CM-10-E1 Summary of A&A: PCP to Enrollee Ratio Report** Summary of Access and Availability: PCP to Enrollee Ratio Report (showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees)	Annual	OnBase
CM-10-E1-ADH	**CM-10-E1-ADH Summary of A&A: PCP to Enrollee Ratio Report** Summary of Access and Availability: PCP to Enrollee Ratio Report (showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees)	Ad-Hoc	OnBase
CM-10-E2	**CM-10-E2 Summary of A&A: PCP Assignment Accuracy** Summary of Access and Availability: PCP Assignment Accuracy	Annual	OnBase
CM-10-E2-ADH	**CM-10-E2-ADH Summary of A&A: PCP Assignment Accuracy** Summary of Access and Availability: PCP Assignment Accuracy	Ad-Hoc	OnBase
CM-10-E3	**CM-10-E3 Summary of A&A: Enrollee Change of PCP** Summary of Access and Availability: Enrollee Change of PCP	Annual	OnBase
CM-10-E3-ADH	**CM-10-E3-ADH Summary of A&A: Enrollee Change of PCP** Summary of Access and Availability: Enrollee Change of PCP	Ad-Hoc	OnBase
CM-10-E4	**CM-10-E4 Summary of A&A: PCP Network Turnover Rate** Summary of Access and Availability: PCP Network Turnover Rate	Annual	OnBase
CM-10-E4-ADH	**CM-10-E4-ADH Summary of A&A: PCP Network Turnover Rate** Summary of Access and Availability: PCP Network Turnover Rate	Ad-Hoc	OnBase
CM-10-F	**CM-10-F Summary of A&A: Specialists to Enrollee Ratio** Summary of Access and Availability: Specialists to Enrollee Ratio; High Volume Specialists, Psychiatrists and OB/GYN Geographic Access)	Annual	OnBase
CM-10-F-ADH	**CM-10-F-ADH Summary of A&A: Specialists to Enrollee Ratio** Summary of Access and Availability: Specialists to Enrollee	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Ratio; High Volume Specialists, Psychiatrists and OB/GYN Geographic Access)		
CM-10-G	**CM-10-G Summary of A&A: Timeliness of Care** Summary of Access and Availability: Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards)	Monthly	OnBase
CM-10-G-ADH	**CM-10-G-ADH Summary of A&A: Timeliness of Care** Summary of Access and Availability: Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards)	Ad-Hoc	OnBase
CM-10-H	**CM-10-H Summary of A&A: Experience Survey** Summary of Access and Availability: Experience Survey	Annual	OnBase
CM-10-H-ADH	**CM-10-H-ADH Summary of A&A: Experience Survey** Summary of Access and Availability: Experience Survey	Ad-Hoc	OnBase
CM-10-I	**CM-10-I Summary of A&A: Use of Out-of- Network Providers** Summary of Access and Availability: Use of Out-of- Network Providers	Annual	OnBase
CM-10-I-ADH	**CM-10-I-ADH Summary of A&A: Use of Out-of- Network Providers** Summary of Access and Availability: Use of Out-of- Network Providers	Ad-Hoc	OnBase
CM-10-J1	**CM-10-J1 Summary of A&A: Pharmacy Network Geographic Access** Summary of Access and Availability: Pharmacy Network Geographic Access	Annual	OnBase
CM-10-J1-ADH	**CM-10-J1-ADH Summary of A&A: Pharmacy Network Geographic Access** Summary of Access and Availability: Pharmacy Network Geographic Access	Ad-Hoc	OnBase
CM-10-J2-ADH	**CM-10-J2-ADH Summary of A&A: Non-Compliant Pharmacies** Summary of Access and Availability: Non-Compliant Pharmacies, if applicable	Ad-Hoc	OnBase
CM-10-K1	**CM-10-K1 Network Provider Report: PCPs and OB/GYNs** Network Provider Report: PCPs and OB/GYNs	Annual	OnBase
CM-10-K1-	**CM-10-K1-ADH Network Provider Report: PCPs and**	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
ADH	**OB/GYNs** Network Provider Report: PCPs and OB/GYNs		
CM-10-K2	**CM-10-K2 Network Provider Report: Acute and Rehabilitation Hospitals and Urgent Care Centers** Network Provider Report: Acute and Rehabilitation Hospitals and Urgent Care Centers	Annual	OnBase
CM-10-K2-ADH	**CM-10-K2-ADH Network Provider Report: Acute and Rehabilitation Hospitals and Urgent Care Centers** Network Provider Report: Acute and Rehabilitation Hospitals and Urgent Care Centers	Ad-Hoc	OnBase
CM-10-K3	**CM-10-K3 Network Provider Report: Physician Specialists** Network Provider Report: Physician Specialists	Annual	OnBase
CM-10-K3-ADH	**CM-10-K3-ADH Network Provider Report: Physician Specialists** Network Provider Report: Physician Specialists	Ad-Hoc	OnBase
CM-10-K4	**CM-10-K4 Network Provider Report: Pharmacies** Network Provider Report: Pharmacies	Annual	OnBase
CM-10-K4-ADH	**CM-10-K4-ADH Network Provider Report: Pharmacies** Network Provider Report: Pharmacies	Ad-Hoc	OnBase
CM-11	**CM-11 Access and Availability-Immediate Notification** Access and Availability-Immediate Notification to EOHHS (only if changes occur that may impact Enrollee access to care, relative to contract standards for geographic access and PCP to enrollee ratio)	Ad-Hoc	OnBase
CM-12	**CM-12Claims Processing Report** Claims Processing Report	Monthly	OnBase
CM-13	**CM-13 Provider Financial Audit** Provider Financial Audit	Annual	OnBase
CM-14	**CM-14 [RETIRED]**		
CM-15	**CM-15 Notification of Scheduled Board of Hearing Cases** Notification of Board of Hearing Cases (Notification: Same Day)	Ad-Hoc	OnBase and secure e-mail
CM-16	**CM-16 Implementation of Board of Hearing Decision** Implementation of Board of Hearing Decision (within 30 days of receipt)	Ad-Hoc	OnBase
CM-17-A	**CM-17-A Enrollee Inquiries Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing	Annual	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Summary: Enrollee Inquiries		
CM-17-B	**CM-17-B Enrollee Grievances Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Grievances	Annual	OnBase
CM-17-C	**CM-17-C Enrollee Internal Appeals Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Internal Appeals	Annual	OnBase
CM-17-D	**CM-17-D Enrollee Board of Hearing Appeals Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee BOH Appeals	Annual	OnBase
CM-17-E	**CM-17-E - Appeals Report (per 1,000 Enrollees)** Appeals Report (per 1,000 Enrollees)	Monthly	OnBase
CM-17-F	**CM-17-F - Grievances Report (per 1,000 Enrollees)** Grievances Report (per 1,000 Enrollees)	Monthly	OnBase
CM-18	**CM-18 Fraud and Abuse Notification (within 10 days) and Activities** Fraud and Abuse Notification (within 10 days) and Activities	Ad-Hoc	OnBase and e-mail
CM-19	**CM-19 Fraud and Abuse Report** Fraud and Abuse Report	Annual	OnBase
CM-20	**CM-20 Notification of For-Cause Provider Suspensions and Terminations** Notification of Provider Suspensions and Terminations	Notification: Within 3 Business Days	OnBase
CM-21	**CM-21 Summary Report of For-Cause Provider Suspensions and Terminations** Summary Report of Provider Suspensions and Terminations	Annual	OnBase
CM-22	**CM-22 ACO/MCO Organization and Key Personnel Changes** Organization and Key Personnel Changes. The Contractor will also include Behavioral Health subcontractor information if applicable.	Ad-Hoc	OnBase
CM-23	**CM-23 Notification of Termination of Material Subcontractor** Notification of Intention to Terminate a Material Subcontractor (Notification: Same Day)	Ad-Hoc	OnBase
CM-24	**CM-24 Notification of New Material Subcontractor** Notification of Intention to Use a New Material Subcontractor (Submit the checklist 60 days prior to requested implementation	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	date)		
CM-25	**CM-25 Material Subcontractor List Annual Summary** Material Subcontractor List Annual Summary	Annual	OnBase
CM-26	**CM-26 Coordination of Benefits / Third Party Liability Report (Appendix H)** Coordination of Benefits / Third Party Liability Report (Appendix H) a. Third Party Health Insurance Cost Avoidance Claims Amount by Carrier b. Third Party Health Insurance Total Recovery Savings by Carrier c. Accident Trauma Recoveries d. Accident/Trauma Cost Avoidance.	Semi-Annual	OnBase
CM-27	**CM-27 Third Party Liability Indicator Form (Appendix H)** Third Party Liability Indicator Form (Appendix H) (Notification: Same Day)	Ad-Hoc	
CM-28	**CM-28 Benefits Coordination Structure (Appendix H)** Benefits Coordination Structure (Appendix H)	Ad-Hoc	OnBase
CM-29	**CM-29 Encounter Data Submission (Appendix E)** Encounter Data Submission (Appendix E)	Monthly	Data Warehouse
CM-30	**CM-30 Sampling of Enrollees To Ensure Services Received** Sampling of Enrollees To Ensure Services Received Were The Same as Providers Billed	Annual	OnBase
CM-31	**CM-31 Notification of Federally Required Disclosures** Notification of Federally Required Disclosures (in accordance with Section 6.1.O and as specified in Appendix L)	Ad-Hoc	OnBase
CM-32	**CM-32 Notification of Reportable Findings /Network FRD** Notification of Reportable Findings /Network FRD (Notification: Same Day)	Ad-Hoc	OnBase
CM-33	**CM-33 Summary of Reportable Findings/Network FRD Forms** Summary of Reportable Findings/Network FRD Forms	Annual	OnBase
CM-34	**CM-34 Notification of Provider Overpayments** Notification of Provider Overpayments	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-35	**CM-35 Summary of Provider Overpayments** Summary of Provider Overpayments	Quarterly	OnBase
CM-36	**CM-36 Provider Materials** Provider Materials (related to enrollee cost-sharing, changes to Covered Services and/or any other significant changes per contractual requirements)	Ad-Hoc	OnBase
CM-37	**CM-37 ACO/MCO Policies and Procedures** ACO/MCO Policies and Procedures (New drafts and any changes to the most recent printed and electronic versions of the Provider procedures and policies which affect the process by which Enrollees receive care (relating to both medical health and Behavioral Health, if separate) for prior review and approval).	Ad-Hoc	OnBase
CM-38	**CM-38 [RETIRED]**		
CM-39	**CM-39 PCP/Enrollee assignment Monthly report** PCP/Enrollee assignment report	Monthly	Data Warehouse
CM-40	**CM-40 PCP/Enrollee assignment report Ad-Hoc** PCP/Enrollee assignment report	Ad-hoc	Data Warehouse
CM-41	**CM-41 Excluded Provider Monitoring Report** Excluded Provider Monitoring Report	Monthly	OnBase
CM-43-A	**CM-43-A Holiday Closures and Other Contractor Office Closures Annual** Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annual	OnBase
CM-43-B	**CM-43-B Emergency Closures and Other Contractor Office Closures Ad Hoc** Emergency Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Ad Hoc	OnBase
CM-44	**CM-44 Strategy-related Reports** Strategy-related Reports	Ad Hoc	OnBase
CM-45	**CM-45 Comprehensive Assessment Report** Comprehensive Assessment Report	Monthly, by the 15th day of the month	OnBase
CM-46	**CM-46 Enrollee and Provider Incentives Notification** Enrollee and Provider Incentives Notification	Ad-Hoc	OnBase
CM-47	**CM-47 [RETIRED]**		

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-48	**CM-48 Copy of Press Releases (pertaining to MassHealth line of business)** Copy of Press Releases (pertaining to MassHealth line of business)	Ad-Hoc	OnBase
CM-49	**CM-49 Written Disclosure of Identified Prohibited Affiliations** Written Disclosure of Identified Prohibited Affiliations	Ad-Hoc	OnBase
CM-50	**CM-50 CM - Self-Reported Disclosures** Self-Reported Disclosures	Ad-Hoc	OnBase
CM-51	**CM-51 Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan** Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan	Annual	OnBase
CM-52	**CM-52 Payment Suspension** Quarterly Payment Suspension Report	Quarterly	OnBase
CM-53	**CM-53 Involuntary Change in PCP Report** Involuntary Change in PCP Report	Ad-Hoc	OnBase
CM-54-A	**CM-54-A Hospital Payment Arrangement Report** Hospital Payment Arrangement Report	Annual	OnBase
CM-54-B	**CM-54-B Hospital Fee Schedule Exemption Form** Hospital Fee Schedule Exemption Form	Ad-Hoc	OnBase
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annual	OnBase

C. Quality Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-01	**QR-01 Quality Improvement Goals (Appendix B, QM/QI work plan)** Quality Improvement Goals (Appendix B) (Includes QM/QI Work plan and Summary List of Enrollees with No Service Utilization. Report needs to be submitted as per Appendix B Reporting Timeline.)	Annual	OnBase
QR-02	**QR-02 CAHPS Report (Submission of full CAHPS Report)** CAHPS Report (Submission of full CAHPS Report)	Annual	OnBase
QR-03	**QR-03 External Research Project Notification** External Research Project Notification	Ad-Hoc	OnBase
QR-04	**QR-04 External Audit/Accreditation** External Audit/Accreditation	Ad-Hoc	OnBase
QR-05	**QR-05 HEDIS IDSS Report** HEDIS IDSS Report	Annual	OnBase
QR-06	**QR-06 Clinical Quality Measures** Clinical Quality Measures	Ad-Hoc	Secure Email
QR-07	**QR-07 Validation of Performance Measures** Validation of Performance Measures	Ad-Hoc	KEPRO
QR-08	**QR-08 Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)** Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs) (*including Health care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs)*	Notification: Within 30 calendar days of occurrence	OnBase
QR-09	**QR-09 Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)** Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)	Annual	OnBase

D. Behavioral Health Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
BH-01	**BH-01 Reportable Adverse Incidents-Daily Incident Delivery Report** Behavioral Health Reportable Adverse Incidents and Roster of Reportable Adverse Incidents-Daily Incident Delivery Report (Notification: Same Day)	Notification: Same Day	Secure Email
BH-02	**BH-02 Behavioral Health Adverse Incident Summary Report** Behavioral Health Adverse Incident Summary Report	Annual	OnBase
BH-03	**BH-03 Behavioral Health Readmission Rates** Behavioral Health Readmission Rates	Annual	OnBase
BH-04	**BH-04 Behavioral Health Ambulatory Continuing Care Rates** Behavioral Health Ambulatory Continuing Care Rates	Annual	OnBase
BH-05	**BH-05 Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status.** Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status.	Daily	MABHA Website
BH-06	**BH-06 Enrollee Access to ESP** Enrollee Access to ESP	Ad hoc	OnBase
BH-08	**BH-08 ABA Service Authorization, Modification and Denial Report** ABA Service Authorization, Modification and Denial Report	Quarterly	OnBase
BH-11	**BH-11 Behavioral Health Medical Records Review Report** Behavioral Health Medical Records Review Report	Annual	OnBase
BH-12	**BH-12 Annual Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria** Annual Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria	Annual	OnBase
BH-13	**BH-13 Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report** Behavioral Health Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report	Quarterly	OnBase
BH-14	**BH-14 CANS Compliance Report** CANS Compliance. This report is required when CANS data is made available through the Virtual Gateway	Quarterly	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
BH-15	**BH-15 Behavioral Health Utilization and Cost Report** Behavioral Health Utilization and Cost Report	Quarterly	OnBase
BH-17	**BH-17 Behavioral Health Inquiries, Grievances, Internal Appeals and BOH** Behavioral Health Inquiries, Grievances, Internal Appeals and BOH	Annual	OnBase
BH-18	**BH-18 Behavioral Health Provider Network Access and Availability** Behavioral Health Provider Network Access and Availability	Ad-hoc and Annual	OnBase
BH-19	**BH-19 Behavioral Health Telephone Statistics** Behavioral Health Telephone Statistics	Annual	OnBase
BH-22	**BH-22 Substance Use Disorder Clinical Ops/Inpatient Authorization Report** Substance Use Disorder Clinical Operations/Inpatient & Acute Service Authorization Modification and Denial Report	Quarterly	OnBase
BH-23	**BH-23 Behavioral Health Fraud and Abuse Report** Fraud and Abuse Report	Quarterly	OnBase
BH-24	**BH-24 Community Support Program for Chronically Homeless Individuals Provider List** Community Support Program for Chronically Homeless Individuals Provider List	Annual	OnBase

E. Financial Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-01	**FR-01 Notification to EHS Regarding Negative Change in Financial Status** Notification to EHS Regarding Negative Change in Financial Status (Notification: Same Day)	Ad-Hoc Notification: Same Day	OnBase
FR-02	**FR-02 Outstanding Litigation Summary** Outstanding Litigation Summary	Annual	OnBase
FR-03	**FR-03 Financial Ratio Analysis** Financial Ratio Analysis\	Annual	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-04B	**FR-04B Experience Review and Revenue Expense Report (F-4B)** Experience Review and Revenue Expense Report (F-4B)	Quarterly and Annual	OnBase
FR-05C	**FR-05C Experience Review and Utilization/Cost Reports (F-5C)** Experience Review and Utilization/Cost Reports (F-5C)	Quarterly and Annual	OnBase
FR-07	**FR-07 Liability Protection Policies** Liability Protection Policies	Annual	OnBase
FR-08	**FR-08 DOI Financial Report (for Plans that are DOI licensed)** DOI Financial Report (for Plans that are DOI licensed)	Quarterly	OnBase
FR-09	**FR-09 Insolvency Reserves** Insolvency Reserves Attestation	Annual	OnBase
FR-10	**FR-10 Lag Triangles and Completion Factors Report (IBNR)** Lag Triangles and Completion Factors Report (IBNR)	Quarterly and Annual	OnBase
FR-11	**FR-11 Description of Incurred But Not Reported (IBNR) Methodology** Description of Incurred But Not Reported (IBNR) Methodology	Annual	OnBase
FR-12	**FR-12 Audited Financial Statements** Audited Financial Statements	Annual	OnBase
FR-13	**FR-13 Attestation Report from Independent Auditors on Effectiveness of Internal Controls** Attestation Report from Independent Auditors on Effectiveness of Internal Controls	Annual	OnBase
FR-14	**FR-14 Financial Relationships Report** Financial Relationships Report	Annual	OnBase
FR-15	**FR-15 Annual Administrative Detail Report** Annual Administrative Detail Report	Annual	OnBase
FR-17	**FR-17 Quarterly Risk Share Report** Quarterly Annual Risk Share Report	Quarterly and Annual	OnBase
FR-18-A	**FR-18-A [RESERVED]**		
FR-18-B	**FR-18-B [RESERVED]**		

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-19	**FR-19 Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year** Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year	Ad-Hoc	OnBase
FR-20	**FR-20 HCV Reconciliation Report** Annual HCV Risk Share Report	Annual	OnBase
FR-21	**FR-21 Maternity and ASD/IDD Supplemental Payment Report** Maternity and ASD/IDD Supplemental Payment Report	Quarterly and Annual	OnBase
FR-22	**FR-22 CBHI Reconciliation Report** CBHI Reconciliation Report	Annual	OnBase
FR-23	**FR-23 Ad Hoc Cash Flow Statement** Ad Hoc Cash Flow Statement	Ad-Hoc	OnBase
FR-24	**FR-24 Report on Any Default of the Contractor's Obligations OR Financial Obligation To A Third Party.** Under This Contract, Or Any Default By A Parent Corporation On Any Financial Obligation To A Third Party That Could In Any Way Affect The Contractor's Ability To Satisfy Its Payment Or Performance Obligations. (Notification should be given Same Day)	Ad-Hoc	OnBase
FR-25	**FR-25 Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures** Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures That May Impact Performance (No later than 30 days prior to execution)	Ad-Hoc No later than 30 days prior to execution	OnBase
FR-26	**FR-26 Provider Risk Arrangements** Provider Risk Arrangements	Ad-Hoc	OnBase
FR-27	**FR-27 Changes in Contractor's Providers' Risk Arrangements** Changes in Contractor's Providers' Risk Arrangements (Notification: Same Day)	Ad-Hoc	OnBase
FR-28	**FR-28 Working Capital Requirement Notification** Working Capital Requirement Notification ("if" working capital falls below 75% below the amount reported on the prior year audited financial reports) (Two Business Days)	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-29	**FR-29 Continuing Services Reconciliation Data** Continuing Services Reconciliation Data	Ad-Hoc	OnBase
FR-30	**FR-30 ABA Reconciliation Report** ABA Reconciliation Report	Annual	OnBase
FR-31	**FR-31 Medical Loss Ratio (MLR) Report** Medical Loss Ratio (MLR) Report	Annually	OnBase
FR-32	**FR-32 Alternative Payment Models (APM) Report** Alternative Payment Models (APM) Report	Quarterly	OnBase
FR-33	**FR-33 Provider Agreements Annual** Provider Agreements Annual	Annual	OnBase
FR-34	**FR-34 Provider Agreements – Ad-Hoc** Provider Agreements – Ad-Hoc	Ad-Hoc	OnBase
FR-35	**FR-35 Report on Satisfying Contractor's Payment Or Performance Obligations** Report on Satisfying Contractor's Payment Or Performance Obligations	Ad-Hoc	OnBase
FR-37	**FR-37 IMD Services Report** Report on services provided to members with long term IMD stay	Quarterly and Annual	OnBase
FR-38	**FR-38 Other High Cost Pharmacy Reconciliation Report** Annual Other High Cost Pharmacy Risk Share Report	Annual	OnBase
FR-39	**FR-39 SUD Reconciliation Report** Annual SUD Risk Share Report	Annual	OnBase
FR-40	**FR-40 Financial Encounter Validation Report** Quarterly Financial Encounter Validation Report	Quarterly and Annual	OnBase
FR-41	**RESERVED**		
FR-42	**FR-42 Certification on Compliance with Appendix Z** Certification on Compliance With Appendix Z	Monthly	As Instructed

F. Operations Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
OP-01	**OP-01 Inbound Pharmacy Co-pay Interface to MMIS per Appendix M** Inbound Pharmacy Co-pay Interface to MMIS per Appendix M	Notification: Same Day	POPS
OP-02	**OP-02 Inbound Managed Care Provider Directory Interface (ACPD)** Inbound Managed Care Provider Directory Interface (ACPD)	Monthly	POSC
OP-03	**OP-03 Long-term Care Report Log** Long-term Care Report Log	Weekly	OnBase
OP-04	**OP-04 Member Discrepancy Report** Member Discrepancy Report	Monthly	OnBase
OP-05	**OP-05 Blank Rate Cell Report** **[RETIRED]**		
OP-06	**OP-06 Address Change File** Address Change File	Bi-Weekly	OnBase
OP-07	**OP-07 Multiple ID File** Multiple ID File	Bi-Weekly	OnBase
OP-08	**OP-08 Date of Death Report** Date of Death Report	Bi-Weekly	OnBase

G. Pharmacy Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-01	**PH-01 Pharmacy Claims Level Interface** Plans use the Pharmacy Claims Level Interface to submit rebate data for Pharmacy claims. The original claims file submission is due **within 5 calendar days** following the close of the prior month.	Monthly	POPS Portal
PH-02	**PH-02 MassHealth Custom Interface Guide - 837 Medication Claims** Plans use the MassHealth Custom Interface Guide - 837 Medication Claims - Paid Claims File Layout for Batch Interface to Pharmacy Systems to submit rebate data for 837 claims. The original claims file submission is due **within 15 calendar days** following the close of the prior month.	Monthly	POPS Portal
PH-03	**PH-03 Pharmacy Provider Network Identification Layout** Pharmacy Provider Network Identification Layout	Ad-Hoc	POPS Portal

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-04-A	**PH-04-A Drug Utilization Review Report** Drug Utilization Review Report *(Note: Due by May 1st of each year)*	Annual	Secure Email
PH-04-B	**PH-04-B Clinical Information request for the DUR Board meeting** Clinical Information request for the DUR board meeting	Ad-Hoc	Email
PH-04-C	**PH-04-C Clinical Criteria for Prior Authorization and Utilization Management** Clinical Criteria for Prior Authorization and Utilization Management	Ad-Hoc	Email
PH-05-A	**PH-05-A Pharmacy MassHealth Drug Rebate File Submission Report** Pharmacy MassHealth Drug Rebate File Submission Report for the plans to self- report monthly on the upload of the report PH-01 to the POPS Portal. The File Submission Report is due within 3 business days following the upload of PH-01.	Monthly	Email
PH-05-B	**PH-05-B 837 MassHealth Drug Rebate File Submission Report** 837 MassHealth Drug Rebate File Submission Report for the plans to self- report monthly on the upload of the report PH-02 to the POPS Portal. The File Submission Report is due within 3 business days following the upload of PH-02.	Monthly	Email
PH-06	**PH-06 837 Registration Form for Access to the MassHealth Drug Rebate Portal** 837 Registration Form for Access to the MassHealth Drug Rebate Portal	Ad-Hoc	OnBase
PH-07	**PH-07 Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal** Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal	Ad-Hoc	OnBase
PH-08	**PH-08 Clinical Policy Initiative Report** Clinical Policy Initiative Report	Ad-Hoc	OnBase
PH-09	**PH-09 MassHealth ACO/MCO Uniform Preferred Drug List Compliance Report** MassHealth ACO/MCO Uniform Preferred Drug List Compliance Report	Ad-Hoc	OnBase
PH-10	**PH-10 Hepatitis C Utilization Report** Hepatitis C Utilization Report	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-11	**PH-11 Pediatric BH Medication Initiative Report** Pediatric BH Medication Initiative Report	Ad-Hoc	OnBase
PH-12-A	**PH-12-A PBM Pricing Report - Quarterly** PBM Pricing Report- Quarterly	Quarterly	POPS Portal, or as directed by EOHHS
PH-12-B	**PH-12-B PBM Pricing Report - Ad-Hoc** PBM Pricing Report- Ad-Hoc	Ad-Hoc	POPS Portal, or as directed by EOHHS
PH-13	**PH-13 Mail Order Pharmacy Program Report** Mail Order Pharmacy Program Report- Ad-Hoc	Ad-Hoc	OnBase
PH-14	**PH-14 Change in BIN/PCN/Group Number Report** Change in BIN/PCN/Group Number Report- Ad-Hoc *(Note: Due at least 30-days before new BIN/PCN/Group Number is effective)*	Ad-Hoc	OnBase
PH-15	**PH-15 Vitrakvi Monitoring Report** Vitrakvi Monitoring Report- Quarterly	Quarterly	OnBase
PH-16-A	**PH-16-A Zolgensma Monitoring Program- Quarterly** Zolgensma Monitoring Program- Quarterly	Quarterly	OnBase
PH-16-B	**PH-16-B Zolgensma Monitoring Program- Annual** Zolgensma Monitoring Program- Annual *(Note: Due February 28 each year)*	Annual	OnBase
PH-17	**PH-17 CAR-T Monitoring Program** CAR-T Monitoring Program-Quarterly	Quarterly	OnBase
PH-18	**PH-18 Controlled Substance Management Program Enrollees Leaving Health Plan** Controlled Substance Management Program Enrollees Leaving Health Plan - Monthly	Monthly	OnBase

APPENDIX B
Quality Improvement Goals

1. INTRODUCTION

This appendix describes the requirements for the Quality Improvement Goals and Performance Measures as specified in **Section 2.13** of the Contract.

2. QI GOAL IMPLEMENTATION

The QI Goal measurement cycle typically includes a planning/baseline period and up to 2 remeasurement cycles to allow for tracking of improvement gains. For each QI Goal cycle, EOHHS will establish a series of QI goal domains as well as approve and/or designate measurement and quality improvement activities for each of those domains. The following paragraphs outline the planning/baseline period for QI Goal Cycle 2.

MCOs are expected to collect and report on all measures and interventions in each QI domain as specified or approved by EOHHS. EOHHS will provide standardized forms for all required reporting activities, including Quality Improvement Plans, Progress Reports, and Annual Reports.

a. QI IMPLEMENATION DETAILS

The following section provides detailed information about the QI Goal implementation periods, their associated activities and timelines.

TABLE 1: QI GOAL IMPLEMENTATION BASELINE PERIOD AND ASSOCIATED ACTIVITIES	
Baseline/Initial Implementation Period: January 1, 2021 – December 31, 2021	• *Planning Phase: January 2021-March 2021* MCOs engage in detailed project planning in an effort to develop a data-driven, evidence-based plan for interventions using quality improvement principles. Project topics are subject to EOHHS approval before detailed planning begins. Project planning tasks include but are not limited to the development of a problem statement, a review of evidence-based literature, and interventions to address the problem, and completion of quality improvement tools and activities that support project planning including root causes analyses, barrier analyses, development of driver diagrams, population analyses. • *Learning Collaboratives: MCOs participate in quality improvement workshops facilitated by EQRO or its designee (January 2021, March 2021, December 2021)* • *Quality Improvement Plan Submission: April 2021* MCOs submit QI proposals to the MassHealth or its designee for review and approval. Proposals will

	describe planned activities and data collection plans for initial implementation. • *Initial Implementation: March 2019-December 2019* MCOs modify QI plans for year 1 based on feedback received from EOHHS. MCOs may focus on developing stakeholder engagement, process mapping and implementation of small test of change to inform initial Implementation. **In September 2021,** MCOs submit progress report detailing **baseline year data as directed by EOHHS or the EQRO, a** description of activities currently underway, and plans for Mid-cycle Implementation.

Figure 1: MCO QI Goals Timeline

Goal Cycle 2 remeasurement period will begin January 1, 2022, and conclude December 31, 2022. However, QI Goal activities, requirements, and domains are subject to change given EOHHS needs and priorities.

b. MCO *QI DOMAIN AREAS AND GOALS: CYCLE 2, Baseline Period*

Domain descriptions and specific goals are outlined in Table 2: Domain Areas and Goals. QI Projects should focus on one or more goals within each domain area.

Table 2: Domain Areas and Goals	
Domain 1: Access to Care - Ensuring the timeliness and availability of health care services to achieve optimal health outcomes.	
2021 Project Focus:	• Reducing barriers to accessing telehealth services for either behavioral or physical health.
Domain 2: Prevention and Wellness. – Reducing the occurrence and complexity of disease while improving level of functioning and quality of life.	
2021 Project Focus:	• Increasing flu vaccinations rates with at least one specific intervention focused on reducing health inequities.

c. DOMAIN MEASURES AND INTERVENTIONS

MCOs will identify specific measures and interventions within their Quality Improvement plans that will be submitted in January 2021 for review and approval by EOHHS or its designee.

d. MCO REPORTS, SUBMISSIONS, AND TEMPLATES

Participating MCOs will submit to MassHealth or its designee:

- One Quality Improvement Plan and one Annual Report during the Planning/Baseline Implementation period;
- One Progress Report and one Annual Report during each re-measurement period.

MCOs should refer to Table 1 (QI Goal Implementation Period and Associated Activities) for reporting timeframes.

MCOs will submit Quality Improvement Plans and Reports using the QI Goals Submission Templates developed and distributed by EOHHS on or before March 1, 2021. QI Goal Reporting submissions shall include quantitative and qualitative data as well as specific progress made to each measure, barriers encountered, lessons learned, and planned next steps. For specific instructions on the submission process and detail on the submission templates, MCOs shall refer to guidance to be distributed on or before March 1, 2021.

Reporting on the interventions should at a minimum include the following items (to be described with greater specificity in the forthcoming Submission Guide Document):

- Rationale for selecting proposed/implemented interventions
- Description of current interventions
- Analysis of short-term indicators, HEDIS rates as applicable, data collection procedures and methodology, and interpretation of results
- Assessment of intervention successes and challenges, and potential intervention modifications for future implementation periods.

Evaluation of QI Reports: EOHHS or its designee will review QI Goal Reports using a standardized Evaluation Template. The scoring elements in the Evaluation Template will correspond directly with the

elements documented on the reporting templates. Feedback will be provided to the MCOs for each implementation period.

Cultural Competency

Participating MCOs shall design and implement all QI Goal activities and interventions in a culturally competent manner.

Appendix B
Exhibit 1: Performance Measures

EOHHS has defined the following performance measures pursuant to **Section 2.13.C.1.a** of the Contract and reserves the right to modify this list as deemed necessary and determined by EOHHS. In accordance with the Medicaid Managed Care Rule, the following performance measures may be used by EOHHS to publicly report MCO performance. EOHHS reserves the right to withhold reporting of a measure(s) as solely determined by EOHHS. EOHHS may further define measure specifications including due dates, sample size and submission requirements where applicable. Additionally, performance measures are subject to modification as solely directed by EOHHS.

#	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	Reporting Level*
1	Childhood Immunization Status	Percentage of members who received all recommended immunizations by their 2nd birthday	Hybrid	NCQA	0038	MCO
2	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	NCQA	1407	MCO
3	Timeliness of Prenatal Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	Hybrid	NCQA	1517	MCO
4	Oral Health Evaluation	Percentage of members under age 21 years who received a comprehensive or periodic oral evaluation during the year	Claims	ADA DQA	2517	MCO (calculated by EOHHS)
5	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800	MCO

6	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	NCQA	0018	MCO
7	Comprehensive Diabetes Care: A1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059	MCO
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Claims	NCQA	2800	MCO
9	ED Visits for Individuals with Mental Illness, Addiction, or Co-occurring Conditions	Risk adjusted ratio (obs/exp) of ED visits for members 18 to 64 years of age identified with a diagnosis of serious mental illness, substance addiction, or co-occurring conditions	Claims	EOHHS	NA	MCO (calculated by EOHHS)
10	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of ED visits for members 6 to 64 years of age with a principal diagnosis of mental illness, where the member received follow-up care within 7 days of ED discharge	Claims	NCQA	2605	MCO
11	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576	MCO
12	Hospital Readmissions (Adult)	Case-mix adjusted rate of acute unplanned hospital readmissions within 30 days of discharge for members 18 to 64 years of age	Claims	NCQA	1768	MCO

13	Behavioral Health Community Partner Engagement	Percentage of members 18 to 64 years of age who engaged with a BH Community Partner and received a treatment plan within 4 months (122 days) of Community Partner assignment	Claims	EOHHS	NA	MCO (calculated by EOHHS)
14	Long-Term Services and Supports Community Partner Engagement	Percentage of members 3 to 64 years of age who engaged with an LTSS Community Partner and received a care plan within 4 months (122 days) of Community Partner assignment	Claims	EOHHS	NA	MCO (calculated by EOHHS)
15	Community Tenure: BH and LTSS Members	Risk adjusted ratio (obs/exp) of eligible days that members with BH diagnoses and/or at least 3 consecutive months of LTSS utilization 0 to 64 years of age reside in their home or in a community setting without utilizing acute, chronic, or post-acute institutional health care services during the measurement year	Claims	EOHHS	NA	MCO (calculated by EOHHS)
16	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis ("Initiation") and who receive at ≥2 additional services within 30 days of the initiation visit ("Engagement")	Claims	NCQA	0004	MCO
17	Acute Unplanned Admissions for Individuals with Diabetes	Case mix adjusted rate of acute unplanned hospital admissions for individuals 18-64 years of age with diabetes	Claims	EOHHS	NA	MCO (calculated by EOHHS)

***Reporting Level** indicates the population for which plans will report rates. As such, administrative and hybrid measures will be reported by the health plan at the MCO contract level and may require the stratification of HEDIS rates reported to NCQA. Non-NCQA claims measures are calculated by EOHHS and reported at the MCO contract level.

APPENDIX P
MCO-Administered ACO Contract Specifications

The Contractor's Approved ACO Agreements (i.e., the Contract between the Contractor and the MCO-Administered ACOs) shall meet the requirements of this **Appendix P** and the requirements of the Contract (i.e. the MassHealth Managed Care Organization Contract between EOHHS and the Contractor). All terms of their abbreviations, when capitalized in this Appendix, are defined as set forth in the Contract or otherwise defined by EOHHS.

Section 1.1 Care Delivery, Care Coordination, and Care Management Requirements for Approved ACO Agreements

The Contractor's Approved ACO Agreements shall obligate the Contractor's MCO-Administered ACOs to ensure that, in addition to Enrollees' other rights, such MCO-Administered ACOs' Attributed Members (i.e. Enrollees who are assigned by the Contractor to one of the MCO-Administered ACO's Participating PCPs) experience care that is integrated across providers, that is Member-centered, and that connects such Attributed Members to the right care in the right settings, as described in this Section and as further specified by EOHHS.

A. General Care Delivery Requirements

   Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall delineate responsibilities and define areas of collaboration between the Contractor and the MCO-Administered ACO as set forth in this Section.

   1. The Approved ACO Agreement shall obligate the MCO-Administered ACO to ensure that all Attributed Members:

      a. Receive care that is timely, accessible, and Culturally and Linguistically Appropriate; and

      b. Access care as described in Section 2.5 of the Contract;

   2. The Approved ACO Agreement shall delineate responsibilities and define areas of collaboration between the Contractor and the MCO-Administered ACO to ensure all requirements in Section 2.5.A of the Contract are met.

B. Care Needs Screening and Appropriate Follow-Up

   Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall delineate responsibilities and define areas of collaboration between the Contractor and the MCO-Administered ACO, including obligating the MCO-Administered ACO as appropriate, to ensure that Attributed Members receive screenings to identify their health and functional needs as specified in Section 2.5.B of the Contract and as follows:

   1. The Approved ACO Agreement shall obligate the MCO-Administered ACO to assist the Contractor in developing, implementing, and maintaining procedures for completing an initial Care Needs Screening for each Attributed Member, and in making best efforts to

complete such screening within required timeframes, as specified in Section 2.5.B.1 of the Contract;

2. The Care Needs Screening shall meet all requirements in Section 2.5.B.2 of the Contract;
3. The Approved ACO Agreement shall obligate the MCO-Administered ACO to assist the Contractor to evaluate Attributed Members' needs through means other than the Care Needs Screenings as described in Section 2.5.B.3 of the Contract;
4. The Approved ACO Agreement shall obligate the MCO-Administered ACO to ensure that Attributed Members receive Medically Necessary and appropriate care and follow-up based on their identified needs as specified in Section 2.5.B.4 of the Contract.

C. Care Coordination, Transitional Care Management, and Clinical Advice and Support Line

Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall delineate responsibilities and define areas of collaboration between the Contractor and the MCO-Administered ACO, including obligating the MCO-Administered ACO as appropriate, to perform care coordination activities for Attributed Members; to have a Transitional Care Management program to coordinate Attributed Members' care during transitions such as hospital discharges; and to maintain a Clinical Advice and Support Line to provide Attributed Members access to information and assistance that supports coordinated care as specified in Section 2.5.C of the Contract and as follows:

1. The Approved ACO Agreement shall obligate the MCO-Administered ACO to perform care coordination for Attributed Members with identified LTSS- or BH-related needs and all Enrollees as specified in Section 2.5.C.1 of the Contract;
2. The Approved ACO Agreement shall obligate the MCO-Administered ACO to have a Transitional Care Management program. The MCO-Administered ACO shall develop, implement, and maintain protocols for Transitional Care Management with all of the MCO-Administered ACO's Affiliated Hospitals. Such protocols shall be as described in Section 2.5.C.2 of the Contract;
3. The Approved ACO Agreement shall obligate the MCO-Administered ACO to assist the Contractor to ensure that the Contractor's Clinical Advice and Support Line meets the requirements in Section 2.5.C.3 of the Contract.

    a. The MCO-Administered ACO shall ensure that the Contractor's Clinical Advice and Support Line's clinicians shall have access to information to identify such Attributed Member's MCO-Administered ACO and other information identified in Section 2.5.C of the Contract and specified by the Contractor relating to facilitating coordination of Enrollee care;

    b. The Clinical Advice and Support Line shall be incorporated in the MCO-Administered ACO's policies and procedures for care coordination and Care Management as specified in Section 2.5.C of the Contract.

    c. The Clinical Advice and Support Line shall otherwise coordinate with an Attributed Member's MCO-Administered ACO, in addition to other coordination specified in Section 2.5.C of the Contract, including through providing "warm handoffs" to such

individuals through direct transfer protocols and processes and capabilities to share information with such entities and individuals;

D. Comprehensive Assessment and Member-Centered Care Planning

Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall obligate the MCO-Administered ACO to ensure that certain Attributed Members receive a Comprehensive Assessment that informs a documented Care Plan, and receive a documented Care Plan, in accordance with Section 2.5.D of the Contract.

E. Care Management

Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall delineate responsibilities and define areas of collaboration between the Contractor and the MCO-Administered ACO, including obligating the MCO-Administered ACO as appropriate, to provide Care Management activities to Attributed Members as described in Section 2.5.E of the Contract, as follow, and as further specified by EOHHS.

1. The Approved ACO Agreement shall delineate responsibilities and define areas of collaboration between the Contractor and the MCO-Administered ACO to, and shall obligate the MCO-Administered ACO to assist the Contractor in, proactively identifying certain Attributed Members who may benefit from Care Management activities based on the results of an evaluation as described in Section 2.5.E.1 of the Contract and further specified by EOHHS;
2. The Approved ACO Agreement shall obligate the MCO-Administered ACO to provide each identified Attributed Member with Care Management as set forth in Section 2.5.E.2 of the Contract.

Section 1.2 Certain Member Protections

Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall obligate the MCO-Administered ACO to:

A. Assist the Contractor to ensure the receipt and timely resolution of Attributed Member's Grievances, which shall include but may not be limited to Grievances related to the MCO-Administered ACO, as described in Section 2.12 of the Contract and as further specified by EOHHS;

B. Ensure that Attributed Members are not limited to obtaining services only from Affiliated Providers of the MCO-Administered ACO. The MCO-Administered ACO shall:

1. Not impose additional requirements for referrals to providers who are not Affiliated Providers;
2. Not impede Attributed Members' access to or freedom of choice of providers;
3. Not reduce or impede access to Medically Necessary services; and
4. Ensure that Attributed Members may obtain emergency services from any provider,

regardless of its affiliation with the MCO-Administered ACO, including but not limited to receiving services from ESP or MCI providers;

C. Ensure that all written materials provided by the MCO-Administered ACO to Attributed Members satisfy all requirements in the Contract related to written materials, such as those set forth in Section 2.10 of the Contract;

D. As further specified by EOHHS, coordinate with the Contractor on the development and distribution of Enrollee materials;

E. Coordinate with the Contractor to ensure interpretation services are available in accordance with all Contract requirements and to notify Attributed Members of this service and how to access it;

F. Post on its website in a prominent place, in multiple languages and formats:

1. Contact information for EOHHS' Ombudsman;
2. A method for submitting inquiries, providing feedback, and initiating Grievances, which shall include but may not be limited to Grievances related to the MCO-Administered ACO, including for Attributed Members who do not have access to email;
3. The identity, contact information, addresses, operating hours, qualifications, and availability of the MCO-Administered ACO's Affiliated Providers;
4. How Attributed Members may access oral interpretation services free-of-charge in any non-English language spoken by Attributed Members;
5. How Attributed Members may access written materials in Prevalent Languages and Alternative Formats;
6. Additional information as specified by EOHHS;

G. Not request that EOHHS disenroll an Attributed Member from the Contractor's plan for any reason, not influence in any way a Participating PCP or the Contractor such that the Participating PCP or Contractor requests that EOHHS disenroll an Attributed Member from the Contractor's plan, and not request that EOHHS disenroll an Attributed Member from the Contractor's plan on behalf of the Contractor;

H. Coordinate with the Contractor to provide Attributed Members with, and have written policies ensuring Attributed Members are guaranteed, the Enrollee rights set forth in Section 5.1.L of the Contract, and ensure that the MCO-Administered ACO's employees and Material Subcontractors observe and respect these rights;

I. Not, in any way, discriminate or use any policy or practice that has the effect of discriminating against Attributed Members on the basis of health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability; and

J. Facilitate Attributed Members' immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in

the community, 24 hours a day, seven days a week;

Section 1.3 Total Cost of Care (TCOC) Accountability Requirements for Approved ACO Agreements

Each of the Contractor's Approved ACO Agreements with an MCO-Administered ACO shall include financial accountability for the MCO-Administered ACO's performance on Total Cost of Care (TCOC) and Quality Measures, as set forth in this Section.

A. Contractor and EOHHS Involvement in TCOC Calculation

1. EOHHS will calculate and provide the Contractor with values related to the TCOC calculations for each of the Contractor's MCO-Administered ACOs. The Contractor shall, for all calculations described in this **Section 1.3** of this **Appendix P**, use such values or other amounts calculated and provided to the Contractor by EOHHS.
2. The Contractor shall provide EOHHS with any requested information or assistance in calculating such values.
3. Values related to the TCOC calculation shall include but may not be limited to:

   a. The MCO-Administered ACO's TCOC Benchmark;

   b. The MCO-Administered ACO's TCOC Performance;

   c. The MCO-Administered ACO's Quality Score;

   d. The MCO-Administered ACO's Shared Savings or Shared Losses payment, as modified by the MCO-Administered ACO's Quality Score; and

   e. Other values as specified by EOHHS.

B. Market-Wide Risk Sharing Arrangement ("Market Corridor") for the Contract Year

1. Overall Approach

   As further described in this section, this risk sharing arrangement shall be based on certain revenue and expenditures across MassHealth managed care plans, described as Market Corridor revenue and Market Corridor expenditures, respectively.

2. Market Corridor Revenue

   EOHHS shall first determine the Market Corridor revenue. For each MassHealth Accountable Care Partnership Plan ("ACPP"), Managed Care Organization ("MCO"), Primary Care Accountable Care Organization ("PCACO"), and the Primary Care Clinician Plan ("PCC Plan") (each a "plan"), EOHHS shall multiply by Region and Rating Category each plan's respective Core Medical component of the Base Capitation Rate or total cost of care (TCOC) benchmark, as applicable, for the Contract Year, per member, per month, by each plan's experienced member months for the Contract Year as determined by EOHHS, and by each plan's concurrent risk scores. The sum of such calculation across plans, plus any supplemental specialized inpatient psychiatric services

payments and benchmark adjustments, as applicable, for each plan, shall equal the Market Corridor revenue.

3. Market Corridor Expenditures

   EOHHS shall then determine the Market Corridor expenditures. Such expenditures shall equal the sum across plans of Core Medical actual medical expenditures related to, covered services (for ACPPs and MCOs), services included in TCOC (for PCACOs) and comparable services for the PCC Plan, including those services related to the supplemental specialized inpatient psychiatric services payments and benchmark adjustments, as applicable, for the applicable Contract Year in aggregate across all Regions and Rating Categories, as applicable, and based on data provided by plans (for ACPPs and MCOs) and EOHHS data (for PCACOs and the PCC Plan).

   a. Such expenditures shall exclude any and all case management costs.

   b. Such expenditures shall exclude expenditures related to stop-loss for which EOHHS makes a plan payment or benchmark adjustment.

   c. EOHHS may make appropriate adjustments as necessary related to the Market Corridor expenditure calculation described above.

4. If the Market Corridor expenditures, as determined by EOHHS in accordance with the above provisions, are greater than or less than the Market Corridor revenue, as determined by EOHHS in accordance with the above provisions, the MCO-Administered ACO's share of the resulting loss or gain shall be an adjustment applied to the MCO-Administered ACO's TCOC Benchmark for the purposes of calculating the MCO-Administered ACO's Shared Savings or Shared Losses below. The MCO-Administered ACO shall share in the resulting loss or gain as follows:

   a. The amount of the Gain on the Market Corridor shall be defined as the difference between the Market Corridor revenue for the Contract Year and the Market Corridor expenditures for the Contract Year, if such Market Corridor expenditures are less than such Market Corridor revenue. The EOHHS Share and the Market Share of the Gain shall be calculated as set forth in the table below. The MCO-Administered ACO's share of the Market share of the Gain shall be a TCOC Benchmark adjustment. Such TCOC Benchmark adjustment shall be applied in a manner directly proportional to the MCO-Administered ACO's TCOC Benchmark divided by the Market Corridor revenue.

Gain	EOHHS Share	Market Share
Less than or equal to 0.75% of the Market Corridor Revenue	0%	100%
Greater than 0.75% of the Market Corridor Revenue	95%	5%

   b. The amount of the Loss on the Market Corridor shall be defined as the difference between the Market Corridor revenue for the Contract Year and the Market Corridor

expenditures for the Contract Year, if such Market Corridor expenditures are greater than such Market Corridor Revenue. The EOHHS Share and the Market Share of the Loss shall be calculated as set forth in the table below. The MCO-Administered ACO's share of the Market share of the Loss shall be a TCOC Benchmark adjustment. Such TCOC Benchmark adjustment shall be applied in a manner directly proportional to the MCO-Administered ACO's TCOC Benchmark divided by the Market Corridor revenue.

Loss	EOHHS Share	Market Share
Less than or equal to 0.75% of the Market Revenue	0%	100%
Greater than 0.75% of the Market Revenue	95%	5%

c. EOHHS shall exclude from all calculations related to this risk sharing arrangement any reinsurance premiums paid by plans and any recovery revenues received if plans choose to purchase reinsurance.

C. Shared Savings or Shared Losses Payment Calculations

The Contractor shall pay the MCO-Administered ACO Shared Savings, or the MCO-Administered ACO shall pay the Contractor Shared Losses, for each Contract Year as follows:

1. If the difference when the MCO-Administered ACO's TCOC Performance is subtracted from the MCO-Administered ACO's Benchmark is equal to an amount greater than zero (0), such difference shall be the MCO-Administered ACO's Savings. If such difference is equal to an amount less than zero (0), such difference shall be the MCO-Administered ACO's Losses. If such difference equals zero (0) and MCO-Administered ACO's TCOC Performance and TCOC Benchmark are equal to each other, the MCO-Administered ACO shall have neither Savings nor Losses for the Contract Year; and
2. If the MCO-Administered ACO has Savings, the Contractor shall pay the MCO-Administered ACO Shared Savings based on the MCO-Administered ACO's Risk Track, as described in **Section 1.3.D** of this **Appendix P,** and based on the MCO-Administered ACO's Quality Score, as described in **Section 1.3.E** of this **Appendix P**.
3. If the MCO-Administered ACO has Losses, the MCO-Administered ACO shall pay the Contractor Shared Losses based on the MCO-Administered ACO's Risk Track, as described in **Section 1.3.D** of this **Appendix P**, and based on the MCO-Administered ACO's Quality Score, as described in **Section 1.3.E** of this **Appendix P**.
4. If the MCO-Administered ACO has neither Savings nor Losses for the Contract Year, the MCO-Administered ACO shall have neither a Shared Savings payment nor a Shared Losses payment.

D. Risk Tracks

1. The MCO-Administered ACO's Risk Track shall be one of the following, as identified to the Contractor by EOHHS:

   a. Risk Track 1 – Limited Accountability;

   b. Risk Track 2 – Moderate Accountability; and

   c. Risk Track 3 – Increased Accountability;

2. The Contractor shall apply Risk Tracks for the TCOC Benchmark, as defined in **Section 1.3.F.2** of this **Appendix P**, as follows:

   a. The Contractor shall pay the MCO-Administered ACO Shared Savings and the MCO-Administered ACO shall pay the Contractor Shared Losses payments for the TCOC Benchmark subject to the following risk corridor provisions:

      1) The minimum savings and losses rate shall both be equal to either one percent (1%) or two percent (2%) of the TCOC Benchmark, as chosen by the MCO-Administered ACO through a defined process and according to a timeline specified by EOHHS (hereinafter "MCO-Administered ACO's chosen minimum savings and losses percentage"). If the MCO-Administered ACO's Savings or the absolute value of the MCO-Administered ACO's Losses are less than the MCO-Administered ACO's chosen minimum savings and losses percentage of the TCOC Benchmark, there shall be no Shared Savings or Shared Losses payment.

      2) The savings and losses cap shall be equal to ten percent (10%) of the TCOC Benchmark (hereinafter referred to as "the cap"). If the MCO-Administered ACO's Savings for the TCOC Benchmark are greater than the cap, the MCO-Administered ACO's Shared Savings payment shall be calculated as if MCO-Administered ACO's Savings were equal to the cap, and the MCO-Administered ACO shall receive no additional Shared Savings payment for any Savings beyond the cap. If the absolute value of the MCO-Administered ACO's Losses for the TCOC Benchmark are greater than the cap, the MCO-Administered ACO's Shared Losses payment shall be calculated as if the absolute value of the MCO-Administered ACO's Losses were equal to the cap, and the MCO-Administered ACO shall make no additional Shared Losses payment for any Losses beyond the cap;

   b. Risk Track 1 – Limited Accountability

      If the MCO-Administered ACO's Risk Track as identified to the Contractor by EOHHS is Risk Track 1 – Limited Accountability, then subject to the provisions in **Section 1.3.D.2.a** of this **Appendix P** above, the MCO-Administered ACO's Shared Savings payment or Shared Losses payment, prior to modifying for the MCO-Administered ACO's Quality Score as described in **Section 1.3.E** of this **Appendix P** below, shall be as follows:

Contract Year	Savings	Contractor Share	MCO-Administered ACO share
Contract Years 4-5	Savings less than or equal to 3% of the TCOC Benchmark	70%	30%
	Savings greater than 3% of the TCOC benchmark	85%	15%

Contract Year	Losses	Contractor Share	MCO-Administered ACO share
Contract Years 4-5	Losses with an absolute value less than or equal to 3% of TCOC Benchmark	70%	30%
	Losses with an absolute value greater than 3% of the TCOC Benchmark	85%	15%

c. Risk Track 2 – Moderate Accountability

If the MCO-Administered ACO's Risk Track as identified to the Contractor by EOHHS is Risk Track 2 – Moderate Accountability, then subject to the provisions in **Section 1.3.D.2.a** of this **Appendix P** above, the MCO-Administered ACO's Shared Savings payment or Shared Losses payment, prior to modifying for MCO-Administered ACO's Quality Score as described in **Section 1.3.E** of this **Appendix P** below, shall be as follows:

Contract Year	Savings	Contractor Share	MCO-Administered ACO Share
Contract Years 4-5	Savings less than or equal to 3% of the TCOC Benchmark	50%	50%
	Savings greater than 3% of the TCOC benchmark	75%	25%

Contract Year	Losses	Contractor Share	MCO-Administered ACO Share
Contract Years 4-5	Losses with an absolute value less than or equal to 3% of TCOC Benchmark	50%	50%
	Losses with an absolute value greater than 3% of the TCOC Benchmark	75%	25%

d. Risk Track 3 – Increased Accountability

If the MCO-Administered ACO's Risk Track as identified to the Contractor by EOHHS is Risk Track 3 – Increased Accountability, then subject to the provisions in **Section 1.3.D.2.a** of this **Appendix P** above, the MCO-Administered ACO's Shared Savings payment or Shared Losses payment, prior to modifying for MCO-Administered ACO's Quality Score as described in **Section 1.3.E** of this **Appendix P** below, shall be as follows:

Contract Year	Savings	MCO Share	MCO-Administered ACO Share
Contract Years 4-5	Savings less than or equal to 3% of the TCOC Benchmark	30%	70%
	Savings greater than 3% of the TCOC benchmark	65%	35%

Contract Year	Losses	MCO Share	MCO-Administered ACO Share
Contract Years 4-5	Losses with an absolute value less than or equal to 3% of TCOC Benchmark	30%	70%
	Losses with an absolute value greater than 3% of the TCOC Benchmark	65%	35%

3. [Reserved]
4. [Reserved]
5. If EOHHS modifies the Risk Tracks, the Contractor agrees to negotiate in good faith to implement such modifications, including but not limited to by amending this **Appendix P** and negotiating in good faith with any MCO-Administered ACOs to implement any such modifications in the Contractor's Approved ACO Agreement.

E. Quality Modifier and Payment

Prior to payment, the MCO-Administered ACO's combined Shared Savings or Shared Losses payment for the TCOC Benchmark calculated in **Sections 1.3.B and 1.3.C** shall be adjusted based on the MCO-Administered ACO's Quality Score. The MCO-Administered ACO or the Contractor shall pay the resulting adjusted amount, as follows:

1. The MCO Administered ACO's Quality Score shall be a number between zero (0) and one (1) as determined by EOHHS;
2. If the MCO Administered ACO has combined Shared Savings for the TCOC Benchmark as calculated above, the amount of such Shared Savings shall be multiplied by MCO-Administered ACO's Quality Score. The resulting amount shall be the amount of the MCO-Administered ACO's Shared Savings payment for the Contract Year, and the

Contractor shall pay the MCO-Administered ACO such resulting amount;

3. If the MCO-Administered ACO has combined Shared Losses for the TCOC Benchmark, eighty percent (80%) of such Shared Losses shall be unmodified by the MCO-Administered ACO's Quality Score. The remaining twenty percent (20%) of MCO-Administered ACO's Shared Losses payment shall be multiplied by an amount equal to one (1) minus the MCO-Administered ACO's Quality Score. Such product, plus the unmodified eighty percent (80%) of MCO-Administered ACO's initial Shared Losses, shall be the amount of MCO-Administered ACO's Shared Losses payment for the Contract Year, and MCO-Administered ACO shall pay the Contractor such resulting amount;
4. The Contractor shall pay the MCO-Administered ACO the Shared Savings payment, as adjusted for the MCO-Administered ACO's Quality Score in this Section, or notify the MCO-Administered ACO of the MCO-Administered ACO's Shared Losses payment for each Contract Year no later than one calendar year from the end of the Contract Year; and
5. The MCO-Administered ACO shall pay the Contractor any Shared Losses payment, as adjusted for MCO-Administered ACO's Quality Score as set forth in this Section, within thirty (30) days of receiving such notification from the Contractor of the amount of the MCO-Administered ACO's Shared Losses payment.

F. TCOC Benchmark and TCOC Performance Calculations

1. The MCO-Administered ACO's TCOC for a given period shall be calculated as follows and as further specified by EOHHS:

   a. TCOC shall be a risk-adjusted per-Attributed Member, per month amount representing the costs of care for Contractor's Attributed Members over such period, excluding Attributed Members in the Special Kids Special Care Program, as described in this Section and further specified by EOHHS;

   b. TCOC shall include all paid claims and encounters with dates of service during such period, where the Member receiving the service was the MCO-Administered ACO's Attributed Member on the date of service, except for services that are not MCO Covered Services as set forth in **Appendix C** of the Contract on the date of service, and all services provided to Attributed Members in the Special Kids Special Care Program;

   c. TCOC shall be based on the amounts paid for such claims and encounters, but shall incorporate certain adjustments to these amounts as further specified by EOHHS to account for effects including but not limited to the different fee schedules historically used by MassHealth and the MassHealth-contracted MCOs and price inflation for certain categories of service (e.g., pharmacy);

   d. Admission-level stop-loss: TCOC shall exclude an amount equal to 95 percent (95%) of allowed expenditures as specified by EOHHS in excess of $150,000 per Attributed Member hospital inpatient admission as determined by EOHHS; and

e. TCOC shall be risk adjusted as further specified by EOHHS using a generally accepted diagnosis grouper and statistically developed risk model. Such risk model may include adjustments for Attributed Members' health-related social needs.

2. The MCO-Administered ACO's TCOC Benchmark shall be calculated each Contract Year according to EOHHS specifications as follows:

   a. The MCO-Administered ACO's Historic TCOC and the MCO-Administered ACO's Market-Rate TCOC shall be calculated as described in this Section;

   b. The MCO-Administered ACO's Historic TCOC and the MCO-Administered ACO's Market-Rate TCOC shall be blended as further specified by EOHHS. Each Contract Year, EOHHS may increase the portion of the blend that is based on the MCO-Administered ACO's Market Rate TCOC, as further specified by EOHHS. The resulting amount shall be the MCO-Administered ACO's TCOC Benchmark.

   c. The MCO-Administered ACO's Historic TCOC shall be calculated as follows:

      1) The MCO-Administered ACO's TCOC shall be calculated during a baseline period, as further specified by EOHHS;

      2) Such TCOC shall be adjusted to account for anticipated trend between the baseline period and the Contract Year, and to account for the anticipated impact of changes to the MassHealth program to ensure that the MCO-Administered ACO is not unfairly penalized or rewarded for such program changes, as further specified by EOHHS;

      3) Such adjusted TCOC shall be the MCO-Administered ACO's Historic TCOC.

   d. The MCO-Administered ACO's Market-Rate TCOC shall be calculated as follows:

      1) The Market-Rate TCOC shall be a risk-adjusted per-Attributed Member, per month amount representing the average anticipated cost for the MCO-Administered ACO's population of Attributed Members based on the market benchmark of all ACO-Eligible Members, as described in this Section and further specified by EOHHS;

      2) Base rates for each EOHHS rating category shall be calculated based on the costs of care for all ACO-Eligible Members in each such rating category during a baseline period, as further specified by EOHHS, and using similar adjustments and exclusions as described above for TCOC calculations;

      3) Such base rates shall be risk adjusted as further specified by EOHHS using a generally accepted diagnosis grouper and statistically developed risk model. Such risk model may include adjustments for Attributed Members' health-related social needs;

4) These base rates shall be averaged across the MCO-Administered ACO's population of Attributed Members based on the number of Attributed Members the MCO-Administered ACO has in each rating category, as further specified by EOHHS;

5) The resulting amount shall be the MCO-Administered ACO's Market-Rate TCOC;

e. In calculating the MCO-Administered ACO's TCOC Benchmark, costs associated with newborn deliveries shall initially be excluded, as further specified by EOHHS. A set per-delivery rate shall instead be developed, and a supplemental maternity amount shall retrospectively be added to the MCO-Administered ACO's TCOC Benchmark. Such supplemental maternity amount shall be calculated by multiplying such per-delivery rate by the number of eligible deliveries the MCO-Administered ACO's Attributed Members receive during the Contract Year. This adjustment is intended to protect Contractor and the MCO-Administered ACO from unfair Shared Savings or Shared Losses payments due to variation in the number of deliveries;

f. The MCO-Administered ACO's preliminary TCOC Benchmark for a Contract Year shall be calculated no later than one month prior to the start of the Contract Year;

g. [Reserved]

h. The MCO Administered ACO's TCOC Benchmark shall be retrospectively adjusted in accordance with **Section 1.3.B** above.

i. Additional retrospective adjustments to the MCO-Administered ACO's TCOC Benchmark may be made to ensure the TCOC Benchmark is appropriate and to ensure the MCO-Administered ACO is not unfairly penalized or rewarded, as further specified and approved by EOHHS. Such adjustments may include but may not be limited to adjustments such as:

1) Additional program changes not initially captured;

2) Modifications to trend based on unforeseen events;

3) Adjustments to reflect updated accounting of the number of Attributed Members in each rating category; and

j. A supplemental specialized inpatient psychiatric services amount may retrospectively be added to the MCO Administered ACO's TCOC Benchmark.

3. The MCO-Administered ACO's TCOC Performance shall be calculated by calculating the MCO-Administered ACO's TCOC during the Contract Year; and

4. EOHHS shall publish the detailed methodology for calculating TCOC Benchmark and TCOC Performance, including details such as the definition of the baseline year and the terms and conditions for any retrospective adjustments to the MCO-Administered ACO's

TCOC Benchmark, prior to the Operational Start Date, and shall publish any subsequent revisions no later than thirty (30) days prior to the start of the Contract Year for which the methodology revisions take effect.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
MH and SA OP Services	90791*	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 189.34
MH and SA OP Services	90791*	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 151.95
MH and SA OP Services	90791*	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 130.44
MH and SA OP Services	90791*	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 131.51
MH and SA OP Services	90791*	HO - Master's Level	Psychiatric Diagnostic Evaluation	$ 117.41
MH and SA OP Services	90791*	U3 - Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 65.22
MH and SA OP Services	90791*	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 58.71
MH and SA OP Services	90792	Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 119.82
MH and SA OP Services	90792	Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 103.92
MH and SA OP Services	90792	Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 95.06
MH and SA OP Services	90832	Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.60
MH and SA OP Services	90832	Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 45.54
MH and SA OP Services	90832	Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 44.22
MH and SA OP Services	90832	Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 29.94
MH and SA OP Services	90832	Intern (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 22.11
MH and SA OP Services	90832	Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 21.44
MH and SA OP Services	90833	Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90833	Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90834	Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 105.18
MH and SA OP Services	90834	Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 92.42
MH and SA OP Services	90834	Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 87.17
MH and SA OP Services	90834	Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 85.91

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90834	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 85.91
MH and SA OP Services	90834	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 85.91
MH and SA OP Services	90834	Intern (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 43.62
MH and SA OP Services	90834	Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 42.96
MH and SA OP Services	90836	Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90836	Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90837	Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 105.18
MH and SA OP Services	90837	Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 92.42
MH and SA OP Services	90837	Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 87.17
MH and SA OP Services	90837	Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$ 85.91
MH and SA OP Services	90837	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$ 85.91
	90837	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$ 85.91
MH and SA OP Services	90837	Intern (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 43.62
MH and SA OP Services	90837	Intern (Master's)	Psychotherapy, 60 minutes	$ 42.96
MH and SA OP Services	90838	Doctoral Level (MD / DO)	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90838	Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90846	Doctor Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 128.56
MH and SA OP Services	90846	Doctor Level (MD/DO)	Family Psychotherapy (without patient present)	$ 97.84
MH and SA OP Services	90846	Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 91.34
MH and SA OP Services	90846	Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 88.68

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90846	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 88.68
MH and SA OP Services	90846	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 88.68
MH and SA OP Services	90846	Intern (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 45.66
MH and SA OP Services	90846	Intern (Master's)	Family Psychotherapy (without patient present)	$ 44.34
MH and SA OP Services	90847	Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 128.56
MH and SA OP Services	90847	Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 97.84
MH and SA OP Services	90847	Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 91.34
MH and SA OP Services	90847	Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	Intern (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 45.66
MH and SA OP Services	90847	Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 44.34
MH and SA OP Services	90849	Doctor Level (Child Psychiatrist)	Multi-family group psychotherapy	42.08
MH and SA OP Services	90849	Doctor Level (MD/DO)	Multi-family group psychotherapy	35.31
MH and SA OP Services	90849	Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	32.60
MH and SA OP Services	90849	Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	30.00
MH and SA OP Services	90849	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	22.17
MH and SA OP Services	90849	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	22.17
MH and SA OP Services	90849	Intern (PhD, PsyD, EdD)	Multi-family group psychotherapy	16.33
MH and SA OP Services	90849	Intern (Master's)	Multi-family group psychotherapy	15.00
MH and SA OP Services	90853	Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 42.08
MH and SA OP Services	90853	Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 35.31

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	90853	Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 32.60
MH and SA OP Services	90853	Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90853	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90853	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90853	Intern (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 16.33
MH and SA OP Services	90853	Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 15.00
MH and SA OP Services	90882	Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 46.46
MH and SA OP Services	90882	Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 40.30
MH and SA OP Services	90882	Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.79
MH and SA OP Services	90882	Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 34.87
MH and SA OP Services	90882	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.48
MH and SA OP Services	90882	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 21.48
MH and SA OP Services	90882	Intern (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 10.91
MH and SA OP Services	90882	Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 10.74
MH and SA OP Services	90887	Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 46.46
MH and SA OP Services	90887	Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.30

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	90887	Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.79
MH and SA OP Services	90887	Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 34.87
MH and SA OP Services	90887	Master's Level (Independently Licensed Clinicians and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.48
MH and SA OP Services	90887	Master's Level (Licensed Alcohol and Drug Counselor 1 and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 21.48
MH and SA OP Services	90887	Intern (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 10.91
MH and SA OP Services	90887	Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 10.74
MH and SA OP Services	96372	Doctoral Level (MD/DO), Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 20.45
MH and SA OP Services	96372	Registered Nurse	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 17.38
MH and SA OP Services	97810		Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 28.41
MH and SA OP Services	97811		Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 21.11
MH and SA OP Services	99202	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 68.41
MH and SA OP Services	99202	Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 59.33
MH and SA OP Services	99202	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 55.25
MH and SA OP Services	99203	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 98.68
MH and SA OP Services	99203	Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 85.58
MH and SA OP Services	99203	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 79.46
MH and SA OP Services	99204	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 149.09
MH and SA OP Services	99204	Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 129.30

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	99204	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 121.14
MH and SA OP Services	99205	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 185.17
MH and SA OP Services	99205	Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 160.59
MH and SA OP Services	99205	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 150.39
MH and SA OP Services	99211	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$ 19.88
MH and SA OP Services	99211	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$ 17.24
MH and SA OP Services	99211	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$ 15.71
MH and SA OP Services	99212	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 40.99
MH and SA OP Services	99212	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 35.55
MH and SA OP Services	99212	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$ 32.49
MH and SA OP Services	99213	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 73.98
MH and SA OP Services	99213	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 63.15
MH and SA OP Services	99213	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$ 54.84
MH and SA OP Services	99214	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 130.89
MH and SA OP Services	99214	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 86.37
MH and SA OP Services	99214	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$ 77.46
MH and SA OP Services	99215	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 130.89
MH and SA OP Services	99215	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 113.52
MH and SA OP Services	99215	Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$ 103.84
MH and SA OP Services	99231	Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 70.97
MH and SA OP Services	99231	Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 53.88
MH and SA OP Services	99231	Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 51.72
MH and SA OP Services	99231	Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 43.15
MH and SA OP Services	99232	Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 106.46
MH and SA OP Services	99232	Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 80.17
MH and SA OP Services	99232	Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 76.96
MH and SA OP Services	99232	Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 64.21
MH and SA OP Services	99233	Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 141.96
MH and SA OP Services	99233	Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 106.90
MH and SA OP Services	99233	Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 102.62

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99233	Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 85.62
MH and SA OP Services	99251	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 95.22
MH and SA OP Services	99251	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 72.27
MH and SA OP Services	99251	Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 69.38
MH and SA OP Services	99251	Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 57.88
MH and SA OP Services	99252	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 142.83
MH and SA OP Services	99252	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 107.56
MH and SA OP Services	99252	Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 103.25
MH and SA OP Services	99252	Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 86.15
MH and SA OP Services	99253	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 190.43
MH and SA OP Services	99253	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 143.40
MH and SA OP Services	99253	Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 137.67
MH and SA OP Services	99253	Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 114.86
MH and SA OP Services	99254	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 255.41
MH and SA OP Services	99254	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 191.80
MH and SA OP Services	99254	Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 153.64
MH and SA OP Services	99255	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 336.47
MH and SA OP Services	99255	Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 252.34
MH and SA OP Services	99255	Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 202.12
MH and SA OP Services	99281	Doctoral Level (MD/DO)	Emergency Department visit for the evaluation and management of a patient, which requires 3 key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.	$ 18.31
MH and SA OP Services	99282	Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.15

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	99282	Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 30.62
MH and SA OP Services	99282	Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 29.73
MH and SA OP Services	99283	Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 48.65
MH and SA OP Services	99283	Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 46.34
MH and SA OP Services	99283	Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 44.99

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

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Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
MH and SA OP Services	99284	Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 91.44
MH and SA OP Services	99284	Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 87.09
MH and SA OP Services	99284	Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 84.55
MH and SA OP Services	99285	Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 135.25

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99285	Doctoral Level (MD/DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 128.81
MH and SA OP Services	99285	Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 123.91
MH and SA OP Services	99404	Doctor (Child / Adolescent MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 153.27
MH and SA OP Services	99404	Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 177.11
MH and SA OP Services	99404	Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 153.27
Diversionary Services	H0015		Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Enhanced Structured Outpatient Addiction Program - SOAP with Motivational Interviewing Counseling)	$ 80.30
Diversionary Services	H0015		Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan) including assessment, counseling; crisis intervention, and activity therapies or education. (Structured Outpatient Addiction Program (SOAP) with Motivational Interviewing)	$ 71.59

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	Procedure Code	Modifier Group	Procedure Description	Unit Cost
Diversionary Services	H2012	+	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	101 CMR 307.00
Diversionary Services	H2012		Behavioral Health Day Treatment, per hour (Enhanced Psychiatric Day Treatment)	$ 13.22
Diversionary Services	H2015	+	Comprehensive community support services, per 15 minutes (Community Support Program)	$ 13.97
Diversionary Services	H2015		Comprehensive community support services, per 15 minutes (Community Support Program - Cultural Broker)	$ 13.97
Diversionary Services	H2015	HF	Recovery Support Navigator , per 15-minute units	101 CMR 444.00
Diversionary Services	H2016	HM	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346.00
Diversionary Services	H2016	HE	When directed by EOHHS, Comprehensive community support services, per diem (Community Support Program (CSP) for members residing in DHCD-funded new temporary shelters)	$ 17.30
Diversionary Services	H2016	HH	Comprehensive community support program, per diem (Enrolled Client Day) (behavioral health service by a navigator trained to support members with justice involvement)	$17.23
Diversionary Services	H2020	+	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	S9484	+	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57
MH and SA OP Services	H0014	+	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
MH and SA OP Services	H0020	+	Alcohol and/or drug services; methadone administration and/or service (Dosing)	$ 11.43
MH and SA OP Services	H0020/T1006		Alcohol and/or drug services; methadone administration and/or service (Family/couple counseling); 1 unit = 60 minutes	$ 84.79
MH and SA OP Services	H0020/H0005		Alcohol and/or drug services; methadone administration and/or service (Group counseling); 1 unit = 60 to 90 minutes	$ 28.68
MH and SA OP Services	H0020		Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 30 minutes	$ 41.16
MH and SA OP Services	H0004		Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 15 minutes	$ 20.58
Adult ESP Services	S9485	U1	Crisis intervention mental health services, per diem (Emergency Service Program Mobile Non-emergency Department)	$ 819.64
Adult ESP Services	S9485	HE	Crisis intervention mental health services, per diem (Emergency Service Program Community Based)	$ 744.23
Adult ESP Services	S9485	HB	Crisis intervention mental health services, per diem (Emergency Service Program Hospital Emergency Room)	$ 505.85
Adult ESP Services	S9485	ET	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 1)	$ 505.53

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Adult ESP Services	S9485	TF	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 2-5)	$ 505.53
Adult ESP Services	S9485	TG	Crisis intervention mental health services, per diem (Emergency Service Program's Adult Community Crisis Stabilization Day 6 and After)	$ 505.53
Other Outpatient	T1004		Specialing - Interpretation - 15 minute units	$ 6.08
Other Outpatient	90870	+	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95
Other Outpatient	96112	Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36
Other Outpatient	96116	Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46
Other Outpatient	96121	Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 105.77
Other Outpatient	96131	Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96132	Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	$ 119.89
Other Outpatient	96133	Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96136	Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96137	Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	Technician	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	$ 37.14

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix T: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule

Commonwealth of Massachusetts Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96139	Technician	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	$ 37.14
Other Outpatient	H0032	Master's Level	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30
Other Outpatient	H0046	Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	Master's Level	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	Addiction Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	Intern (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74
Other Outpatient	H2028		Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79
MH and SA OP Services	H0001-U1		Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	101 CMR 444.00
MH and SA OP Services	H0033		Oral medication administration, with extended direct observation up to 2.5 hours (buprenorphine and associated drug screens, to be billed once during induction); may not be combined with H0033-U2	101 CMR 444.00
MH and SA OP Services	H0047		Alcohol and/or other drug abuse services, not otherwise specified; oral medication preparation and administration (buprenorphine and associated drug screens); may not be combined with H0033; may be billed once per each day a member receives	$ 10.36
MH and SA OP Services	H0001-U2		Oral medication administration, direct observation (oral naltrexone dosing)	$ 9.45
MH and SA OP Services	J0571		Buprenorphine, oral, 1 mg (maximum 32 mg per day) (prior authorization required)	101 CMR 444.00
MH and SA OP Services	J0572		Buprenorphine/naloxone, oral, less than or equal to 3 mg (maximum of one unit per day; may be combined with J0573 as medically necessary)	101 CMR 444.00
MH and SA OP Services	J0573		Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg; (may be billed in sufficient increments to achieve appropriate dose, may be combined with one unit of J0572 as medically necessary)	101 CMR 444.00
MH and SA OP Services	J2315		Injection, naltrexone, depot form, 1 mg (maximum of 380 mg. per month)	101 CMR 444.00
MH and SA OP Services	J3490		Unclassified drugs (Naltrexone, oral)	101 CMR 444.00

* See Section 2.7.C.2.e.1 for adjustment to unit cost if using CANS Tool.

Appendix Z

Directed Payments Related to COVID-19

Exhibit 1: Summary of Rate Increases by Service

Covered Service	Increase	Rate Increase Effective Date	Rate Increase End Date
Acute Hospital services - DRG specific (See Exhibit 1.A.1 for the specific DRGs subject to the rate increase)*`^	20% increase to weights for those DRGs	3/10/2020	10/31/2020
Acute Hospital services - DRG specific, narrowed set of codes (See Exhibit 1.A.2 for the specific DRGs subject to the rate increase)*^	20% increase to weights for a narrower set of DRGs	11/01/2020	The end of the state-declared public health emergency
Acute Hospital services - (inpatient and outpatient)*^	7.5% for base rates for inpatient (including capital and operating standards) and outpatient	4/1/2020	7/31/2020
Ambulance services (See Exhibit 1.B for the codes subject to the rate increase)	50% rate increase	4/1/2020	7/31/2020
Home Health services (See Exhibit 1.C for the codes subject to the rate increase)	10% rate increase	4/1/2020	7/31/2020
Physician services (See Exhibit 1.D for the codes subject to the rate increase)	15% rate increase	4/1/2020	7/31/2020
Diversionary and Outpatient Behavioral Health services **(**See Exhibit 1.E.1 for the codes subject to the rate increase)	10% rate increase	4/1/2020	7/31/2020
Residential Rehabilitation Services (See Exhibit 1.E.2 for the codes subject to the rate increase)+	10% rate increase	4/1/2020	7/31/2020
	15% incremental rate increase	5/1/2020	6/30/2020
Early Intervention Services (See Exhibit 1.F for the codes subject to the rate increase)	10% rate increase	4/1/2020	7/31/2020

* The "Acute Hospital - DRG Specific services" and "Acute Hospital (inpatient and outpatient) services" rate increases apply to all acute hospitals, including pediatric hospitals, hospitals with pediatric specialty units and specialty cancer hospitals. The rate increases included in this bulletin do not change the requirements found in Section 2.7.D.6 of the Contract related to payment rates for hospitals.

` Effective 11/1/2020, a subset of the Acute Hospital – DRG specific services were removed from the 20% rate increase. As shown in exhibit 1.A.2, there is a narrower set of DRGs still applicable to the 20% increase to the weights.

^ For clarity, the "Acute Hospital - DRG Specific services" and "Acute Hospital (inpatient and outpatient) services" rate increases may apply multiplicatively to payment (e.g., for inpatient discharges with DRGs in Exhibit 1.a, where the base rate increases by 7.5% and the weight by 20%).

\+ For clarity, the "Residential Rehabilitation Services" rate increases will apply additively to payment between 5/1/2020 and 6/30/2020 (i.e., for Residential Rehabilitation Services in Exhibit 1.e.2, payment will be multiplied as follows: April: 1.1X, May: 1.25X, June: 1.25X, July: 1.1X).

Exhibit 1.A.1: Acute Hospital Service DRGs effective 3/10/2020 through 10/31/2020

DRG and SOI	DRG Description
4-1	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
4-2	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
4-3	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
4-4	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
5-1	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
5-2	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
5-3	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
5-4	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
113-1	INFECTIONS OF UPPER RESPIRATORY TRACT
113-2	INFECTIONS OF UPPER RESPIRATORY TRACT
113-3	INFECTIONS OF UPPER RESPIRATORY TRACT
113-4	INFECTIONS OF UPPER RESPIRATORY TRACT
120-1	MAJOR RESPIRATORY & CHEST PROCEDURES
120-2	MAJOR RESPIRATORY & CHEST PROCEDURES
120-3	MAJOR RESPIRATORY & CHEST PROCEDURES
120-4	MAJOR RESPIRATORY & CHEST PROCEDURES
121-1	OTHER RESPIRATORY & CHEST PROCEDURES
121-2	OTHER RESPIRATORY & CHEST PROCEDURES
121-3	OTHER RESPIRATORY & CHEST PROCEDURES
121-4	OTHER RESPIRATORY & CHEST PROCEDURES
130-1	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
130-2	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
130-3	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
130-4	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
131-1	CYSTIC FIBROSIS - PULMONARY DISEASE
131-2	CYSTIC FIBROSIS - PULMONARY DISEASE
131-3	CYSTIC FIBROSIS - PULMONARY DISEASE
131-4	CYSTIC FIBROSIS - PULMONARY DISEASE
133-1	RESPIRATORY FAILURE
133-2	RESPIRATORY FAILURE
133-3	RESPIRATORY FAILURE
133-4	RESPIRATORY FAILURE
134-1	PULMONARY EMBOLISM
134-2	PULMONARY EMBOLISM

DRG and SOI	DRG Description
134-3	PULMONARY EMBOLISM
134-4	PULMONARY EMBOLISM
136-1	RESPIRATORY MALIGNANCY
136-2	RESPIRATORY MALIGNANCY
136-3	RESPIRATORY MALIGNANCY
136-4	RESPIRATORY MALIGNANCY
137-1	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
137-2	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
137-3	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
137-4	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
138-1	BRONCHIOLITIS & RSV PNEUMONIA
138-2	BRONCHIOLITIS & RSV PNEUMONIA
138-3	BRONCHIOLITIS & RSV PNEUMONIA
138-4	BRONCHIOLITIS & RSV PNEUMONIA
139-1	OTHER PNEUMONIA
139-2	OTHER PNEUMONIA
139-3	OTHER PNEUMONIA
139-4	OTHER PNEUMONIA
140-1	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
140-2	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
140-3	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
140-4	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
141-1	ASTHMA
141-2	ASTHMA
141-3	ASTHMA
141-4	ASTHMA
142-1	INTERSTITIAL & ALVEOLAR LUNG DISEASES
142-2	INTERSTITIAL & ALVEOLAR LUNG DISEASES
142-3	INTERSTITIAL & ALVEOLAR LUNG DISEASES
142-4	INTERSTITIAL & ALVEOLAR LUNG DISEASES
143-1	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES
143-2	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES
143-3	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES
143-4	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES
144-1	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES
144-2	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES
144-3	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES

DRG and SOI	DRG Description
144-4	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES
145-1	ACUTE BRONCHITIS AND RELATED SYMPTOMS
145-2	ACUTE BRONCHITIS AND RELATED SYMPTOMS
145-3	ACUTE BRONCHITIS AND RELATED SYMPTOMS
145-4	ACUTE BRONCHITIS AND RELATED SYMPTOMS
720-1	SEPTICEMIA & DISSEMINATED INFECTIONS
720-2	SEPTICEMIA & DISSEMINATED INFECTIONS
720-3	SEPTICEMIA & DISSEMINATED INFECTIONS
720-4	SEPTICEMIA & DISSEMINATED INFECTIONS

Exhibit 1.A.2: Acute Hospital Service DRGs, narrowed list effective 11/01/2020 through the end of the state-declared public health emergency

DRG and SOI	DRG Description
4-1	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
4-2	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
4-3	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
4-4	TRACHEOSTOMY W MV 96+ HOURS W EXTENSIVE PROCEDURE
5-1	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
5-2	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
5-3	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
5-4	TRACHEOSTOMY W MV 96+ HOURS W/O EXTENSIVE PROCEDURE
130-1	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
130-2	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
130-3	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
130-4	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS
137-1	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
137-2	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
137-3	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
137-4	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS
720-1	SEPTICEMIA & DISSEMINATED INFECTIONS
720-2	SEPTICEMIA & DISSEMINATED INFECTIONS
720-3	SEPTICEMIA & DISSEMINATED INFECTIONS
720-4	SEPTICEMIA & DISSEMINATED INFECTIONS

Exhibit 1.B: Codes for Certain Ambulance Services

Code	Description
A0425	Ground mileage (per statute mile) (Loaded Mileage)
A0426	Ambulance service, Advanced Life Support, non-emergency, level 1 (ALS 1)
A0427	Ambulance service, Advanced Life Support, emergency, level 1 (ALS 1 - Emergency)
A0428	Ambulance service, Basic Life Support, non-emergency (BLS)
A0429	Ambulance service, Basic Life Support, emergency (BLS-Emergency)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0433	Advanced Life Support, Level 2 (ALS 2)
A0434	Ambulance service Specialty Care Transport (SCT)
A0998	Ambulance response and treatment; no transport (Used for medically necessary visits to patients to obtain and transport specimens for COVID-19 diagnostic testing)

Exhibit 1.C: Codes for Home Health Services

Code	Modifier	Service Description
G0299		Services of an RN in home health setting (one through 30 calendar days)
G0299	UD	Services of an RN in home health setting (31+ calendar days)
G0299	U3	Nursing care visit for temporary emergency PCA services
G0300		Services of an LPN in home health setting (one through 30 calendar days)
G0300	UD	Services of an LPN in home health setting (31+ calendar days)
G0300	U3	Nursing care visit for temporary emergency PCA services
G0493		Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition (PA required prior to start of care)
T1502		Administration of oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) (Use only for Medication Administration visit.)
T1503		Administration of medication other than oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) (Use only for Medication Administration visit.)
G0156		Services of Home Health Aide in the home health setting
G0156	UD	Services of home health aide in the home health setting (ADL support) (15 minute units) (PA required prior to start of care)
G0151		Services of Physical Therapist in the home health setting
G0152		Services of Occupational Therapist in the home health setting
G0153		Services of Speech-Language Pathologist in the home health setting
99509		Home health aide visit for temporary emergency PCA services

Exhibit 1.D: Codes for Certain Physician Services

Surgery and Anesthesia

00170
00731
00790
00840
01961
01967
17110
20610
31231
43239
45380
45385
47562
59400
59409
59410
59426
59510
59514
66984
88305
88307

Medicine

90460
90461
90471
90834
90960
92004
92012
92014
93010
93306
95004
95165
95712[1]
95715[2]
95810
96110
98941
99202
99203
99204
99205
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99480

Radiology

70450
70551
70553
71045
71046
71260
72148
73721
74176
74177
76801
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76830
76856
77067
78815

[1]This new code crosswalks to CPT code 95951, which was deleted effective January 1, 2020.
[2]This new code crosswalks to CPT code 95951, which was deleted effective January 1, 2020.

Exhibit 1.E: Codes for Certain Diversionary and Outpatient Behavioral Health Services

Exhibit 1.E.1 Codes for Diversionary and Outpatient Behavioral Health Services

Service	Code	Description
Applied Behavior Analysis	H2019-U2	Therapeutic behavioral services, per 15 minutes (Direct instruction by a paraprofessional working under the supervision of a licensed professional.)
Applied Behavior Analysis	H2012-U2	Behavioral health day treatment, per hour (Direct instruction by a licensed professional/parent training for home services by a licensed professional.)
Applied Behavior Analysis	H0031-U2	Mental health assessment, by nonprofessional (Assessment and case planning for home services by a licensed professional. 15-minute rate.)
Applied Behavior Analysis	H0032-U2	Mental health service plan development by nonphysician (Supervision for home services by a licensed professional. 15-minute rate.)
Children's Behavioral Health Initiative	H0038	Self-help/peer services, per 15 minutes (parent-caregiver peer-to-peer support service provided by a family partner)
Children's Behavioral Health Initiative	H2011-HN	Crisis intervention service, per 15 minutes (mobile crisis intervention service provided by a paraprofessional)
Children's Behavioral Health Initiative	H2011-HO	Crisis intervention service, per 15 minutes (mobile crisis intervention service provided by a master-level clinician)
Children's Behavioral Health Initiative	H2014-HN	Skills training and development, per 15 minutes (behavior management monitoring provided by a bachelor-level clinician)
Children's Behavioral Health Initiative	H2014-HO	Skills training and development, per 15 minutes (behavior management therapy provided by a master-level clinician)
Children's Behavioral Health Initiative	H2019-HN	Therapeutic behavioral services, per 15 minutes (therapeutic training and support services provided by a bachelor-level clinician)
Children's Behavioral Health Initiative	H2019-HO	Therapeutic behavioral services, each 15 minutes (in-home therapy provided by a master-level clinician)
Children's Behavioral Health Initiative	T1027-EP	Family training and counseling for child development, per 15 minutes (therapeutic mentoring service)
Children's Behavioral Health Initiative	H0023-HT	Behavioral Health Outreach Service (Targeted Case Management) (multi-disciplinary team) that includes family support and training and intensive care coordination per day
Program for Assertive Community Treatment	H0040	Assertive community treatment program, per diem (PACT programs with 50 slots)
Program for Assertive Community Treatment	H0040	Assertive community treatment program, per diem (PACT programs with 80 slots)
Program for Assertive Community Treatment	H0040	Assertive community treatment program, per diem (Forensic program)

Service	Code	Description
Opioid Treatment Services	H0020	Alcohol and/or drug services; methadone administration and/or service (Dosing)
Opioid Treatment Services	H0020/T1006	Alcohol and/or drug services; methadone administration and/or service (Family/couple counseling); 1 unit = 60 minutes
Opioid Treatment Services	H0020/H0005	Alcohol and/or drug services; methadone administration and/or service (Group counseling); 1 unit = 60 to 90 minutes
Opioid Treatment Services	H0020	Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 30 minutes
Opioid Treatment Services	H0004	Alcohol and/or drug services; methadone administration and/or service (Individual counseling); 1 unit = 15 minutes
Acute Treatment Services	H0011*	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) (Medically Monitored Inpatient Detoxification Services, Facility)
Clinical Stabilization Services	H0010*	Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient) (Clinically Managed Detoxification Services)
Psychological Testing Services	96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour (Doctoral level)
Psychological Testing Services	96121	Each additional hour (List separately in addition to code for primary procedure) (Doctoral level)
Psychological Testing Services	96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
Psychological Testing Services	96131	Each additional hour (List separately in addition to code for primary procedure)
Psychological Testing Services	96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
Psychological Testing Services	96133	Each additional hour (List separately in addition to code for primary procedure)

Service	Code	Description
Psychological Testing Services	96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)
Psychological Testing Services	96137	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)
Psychological Testing Services	96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
Psychological Testing Services	96139	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)

*Note: The rate increases described above apply to all code(s) used by managed care plans for this service.

Exhibit 1.E.2 Codes for Residential Rehabilitation Services

Service	Code	Description
Adult Residential Rehabilitation Services	H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (substance abuse program)
Family Residential Rehabilitation Services	H0019-HR	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (substance abuse program)
Adult Residential Rehabilitation Services	H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (substance abuse program)
Family Residential Rehabilitation Services	H0019-HR	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (substance abuse program)
Youth Residential Rehabilitation Services	H0019-HA	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (substance abuse program)
Transitional Age Youth and Young Adult Residential Rehabilitation Services	H0019-HF	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem (substance abuse program)
Pregnant Residential Rehabilitation Services	H0019-TH	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
Co-Occurring Enhanced Residential Rehabilitation Services	H0019-HH	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem

Exhibit 1.F: Codes for Early Intervention Services

Service	Code	Description
Early Intervention	H2015	Child visit – day care
Early Intervention	H2015	Child visit – hospital
Early Intervention	H2015	Child visit
Early Intervention	T1015	Center-based individual
Early Intervention	96165-U1	EI-only child group (15 minutes)
Early Intervention	96164-U1	EI-only child group (30 minutes)
Early Intervention	96165-U2	Community child group (15 minutes)
Early Intervention	96164-U2	Community child group (30 minutes)
Early Intervention	T1027	Parent-focused group
Early Intervention	T1023	Screening
Early Intervention	T1024	Assessment

Exhibit 2: Codes for Services Related to COVID-19 Specimen Collection and Testing Minimum Payment Requirement

Exhibit 2.A - Specimen Collection

CODE	FOR DATES OF SERVICE ON OR AFTER	DESCRIPTION
G2023	March 12, 2020	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source;
G2024	March 12, 2020	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source
G2023 CG	May 22, 2020	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source. [Used when provider 1) has a qualified ordering clinician present at the specimen collection site available to order medically necessary COVID-19 diagnostic tests; and 2) ensures the test results are provided to the patient (along with any initial follow-up counseling, as appropriate), either directly or through the patient's ordering clinician.]
G2024 CG	May 22, 2020	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source. [Used when provider 1) has a qualified ordering clinician present at the specimen collection site available to order medically necessary COVID-19 diagnostic tests; and 2) ensures the test results are provided to the patient (along with any initial follow-up counseling, as appropriate), either directly or through the patient's ordering clinician.]

Exhibit 2.B - Diagnostic and Laboratory Testing Services

CODE	FOR DATES OF SERVICE ON OR AFTER	DESCRIPTION
U0002	March 12, 2020	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets).
87635	March 12, 2020	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
U0003	March 18, 2020	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R.
U0004	March 18, 2020	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R
86328	April 10, 2020	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).
86769	April 10, 2020	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).