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):** WellSense Health Plan	**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS
Legal Address: (W-9, W-4): 529 Main St., Ste. 500, Charlestown, MA, 02129	**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108
Contract Manager: Nelie Lawless **Phone:** 617-791-9346	**Billing Address (if different):**
E-Mail: Nelie.Lawless@wellsense.org **Fax:**	**Contract Manager:** Alejandro Garcia Davalos **Phone:** 617-838-3344
Contractor Vendor Code: VC7000072388	**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov **Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**	**MMARS Doc ID(s):** N/A **RFR/Procurement or Other ID Number:** BD-17-1039-EHS01-EHS01-10209

☐ NEW CONTRACT

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

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

☒ CONTRACT AMENDMENT

Enter **Current Contract End Date *Prior*** to Amendment: **March 31, 2023.**

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 Fifth Amended and Restated MCO Contract with Boston Medical Center HealthNet Plan updates various provisions and replaces certain appendices in the Contract effective April 1, 2023.

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

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

☒ 2. may be incurred as of **April 1, 2023**, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.

☐ 3. were incurred as of _____, 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, 2023,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

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

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:

X: Heather Thiltgen **Date:** 10/25/23

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

Print Name: Heather Thiltgen

Print Title: President & CEO

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: Mike Levine **Date:** 10/31/2023

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

Print Name: Mike Levine

Print Title: Assistant Secretary for MassHealth

AMENDMENT #2

TO THE

FIFTH 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;

WHEREAS, EOHHS and the Contractor last amended and restated the Contract effective April 1, 2023, (the Fifth Amended and Restated Managed Care Organization Contract);

WHEREAS, EOHHS and the Contractor amended the Contract through Amendment #1 (April 1, 2023) and Amendment 1A (September 8, 2023);

WHEREAS, in accordance with **Section 5.8** of the Contract, EOHHS and the Contractor desire to further amend the Contract effective April 1, 2023; and

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

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

1. **Section 2** is hereby amended by deleting "Health Equity Committee" and "HEC" in each instance in which they appear and inserting in place thereof, respectively, the following: "Health Quality and Equity Committee" and "HQEC".

2. **Section 2** is hereby amended by deleting "Health Equity Incentive" in each instance in which it appears and inserting in place thereof the following: "Quality and Equity Incentive Program" in each instance it occurs.

3. **Section 2.3.A.3.a** is hereby amended by deleting "and" at the end of **Section 2.3.A.3.a.14**, inserting a new **Section 2.3.A.3.a.15** as follows and renumbering subsequent sections accordingly:

    "15) The Contractor's Designated Pediatric Expert, who shall assist with MCO Care Management strategy matters, screening matters, and other matters as they relate to Enrollees under 21 as further described in this Contract, including but not limited to in **Sections 2.5 and 2.6**; and"

4. **Section 2.4.E.6.b.4** is hereby amended by deleting **Section 2.4.E.6.i-j** in their entirety and inserting in place thereof the following:

    "i) Enrollees with substance use disorders inclusive of opioid use disorder and alcohol use disorder;

    j) Adults with Co-Occurring Disorders; and

    k) High-risk perinatal Enrollees;"

5. **Section 2.5.B.3.d.1** is hereby amended by inserting "and" at the end of **Section 2.5.B.3.d.1.e** and deleting **Sections 2.5.B.3.d.1.g-h**.

6. **Section 2.5.C.1.c** is hereby amended by inserting ", breastfeeding education, " after "education".

7. **Section 2.5.F.1.e.6** is hereby amended by inserting " Recovery Support Navigator, if any," after "Inclusion of the Enrollee's Behavioral Health Provider, if any,".

8. **Section 2.6.E.9.a** is hereby amended by deleting "account for a homelessness add-on" in its entirety and inserting in place thereof the following "account for certain add-ons".

9. **Section 2.7.B.2.a** is hereby amended by deleting the first instance of "and" and inserting " , and pharmaceutical compounded drugs" after "over-the-counter drugs".

10. **Section 2.7.B.3.h** is hereby amended by inserting a new **Section 2.7.B.3.h.4** as follows:

    "4) The Contractor shall comply with all applicable laws, regulations, and related EOHHS policies regarding exceptions to step therapy."

11. **Section 2.7.B.5.b** is hereby amended by inserting " drugs and" after "With respect to".

12. **Section 2.7.E.3.i** is hereby amended by deleting **Section 2.7.E.3.i** in its entirety and inserting a new **Section 2.7.E.3.i** as follows:

    "i. Ensure prior authorization shall not be required for Inpatient Substance Use Disorder Services (Level 4); Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7), including Youth and Transitional Age Youth Detoxification and Stabilization Services; Clinical Support Services for Substance Use Disorders (Level 3.5), including Youth and Transitional Age Youth Detoxification and Stabilization Services; and Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) as defined in **Appendix C**;"

13. **Section 2.8.C.1** is hereby amended by deleting **Section 2.8.C.1.c** in its entirety and inserting a new **Section 2.8.C.1.c** as follows:

"c. For Contract Year 1, have a minimum term of 9 months from the Contract Operational Start Date. For all other Contract Years, have a term of no less than one year, ending not before the last day of the calendar year; and"

14. **Section 2.8.D.7.d** is hereby amended by inserting "and Youth and Transitional Age Youth Detoxification and Stabilization Services" after "Individualized Treatment Services".

15. **Section 2.8.D.7.e** is hereby amended by inserting "and Youth and Transitional Age Youth Detoxification and Stabilization Services" after "Individualized Treatment Services".

16. **Section 2.8.D.7** is hereby amended by, effective July 1, 2023, deleting **Section 2.8.D.7.o** in its entirety and existing **Section 2.8.D.7.p** shall be renumbered **Section 2.8.D.7.o** as a result.

17. **Section 2.8.D.7** is hereby amended by inserting the following new **Sections 2.8.D.7.p-t**:

"p. As further specified by EOHHS, pay for drugs on the MassHealth Acute Hospital Carve-Out Drugs List consistent with the methodology EOHHS uses in its fee-for-service program.

q. Effective October 1, 2023, for behavioral health crisis evaluation services in medical or surgical inpatient and emergency department settings, the Contractor shall establish Provider rates at or above the rate specified in the MassHealth Acute Hospital Request for Application (RFA) unless otherwise directed by EOHHS and shall use procedure codes as directed by EOHHS to provide payment for such services.

r. Effective October 1, 2023, for behavioral health crisis management services in medical or surgical inpatient and emergency department settings, the Contractor shall establish Provider rates at or above the rate specified in in the MassHealth Acute Hospital Request for Application (RFA) unless otherwise directed by EOHHS and shall use procedure codes as directed by EOHHS to provide payment for such services.

s. Effective October 1, 2023, the Contractor shall provide specialized inpatient psychiatric services to Enrollees with an eating disorder diagnosis and severe associated psychiatric and medical needs in specialized eating disorder inpatient psychiatric treatment settings, as directed by EOHHS.

1) The Contractor shall report claims paid for psychiatric inpatient services delivered to Enrollees with an eating disorder diagnosis and severe associated psychiatric and medical needs in specialized eating disorder inpatient psychiatric treatment settings to EOHHS in a form and format and at a frequency to be determined by EOHHS;

2) The Contractor shall pay Providers no less than the rate specified by EOHHS in the MassHealth Psychiatric Hospital RFA as further specified by EOHHS, for inpatient psychiatric services delivered to Enrollees with an eating disorder diagnosis and severe associated psychiatric and medical

needs in specialized eating disorder inpatient psychiatric treatment settings;

t. Effective October 1, 2023, for evaluation of Enrollees for opioid use disorder and initiation of Medication for Opioid Use Disorder (MOUD) in the Emergency Department, the Contractor shall establish Provider rates at or above the rate 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."

18. **Section 2.9.C.6.d** is hereby amended by inserting "including when provided in Emergency Departments and medical and surgical inpatient settings for dates of service after October 1, 2023," after "services,".

19. **Section 2.9.Q** is hereby amended by deleting **Section 2.9.Q** in its entirety, inserting a new **Section 2.9.Q**:

"Q. Behavioral Health Crisis Evaluation and Management Services

1. Behavioral Health Crisis Evaluation (through September 30, 2023)

a. The Contractor shall pay hospitals for Emergency Department-based behavioral health crisis evaluations as set forth in **Appendix C** at or above the rate specified by EOHHS. Hospitals may sub-contract these services out to behavioral health providers, including crisis teams, but hospitals shall be solely responsible for billing the Contractor unless otherwise directed by EOHHS. In addition, the Contractor shall direct hospitals to deliver ED-based behavioral health crisis evaluations in accordance with the Acute Hospital RFA as specified by EOHHS.

b. Once all hospitals have established procedures for Emergency Department-based behavioral health crisis evaluations, as determined by EOHHS, the Contractor shall not make payments to Emergency Service Programs and Mobile Crisis Intervention teams for ED-based behavioral health crisis evaluations provided in the Emergency Department.

2. Behavioral Health Crisis Evaluation (effective October 1, 2023)

a. The Contractor shall pay hospitals for behavioral health crisis evaluations in medical or surgical inpatient and emergency department settings set forth in **Appendix C** in accordance with **Section 2.8.D.7.q**. Hospitals may sub-contract these services out to behavioral health providers, including crisis teams, but hospitals shall be solely responsible for billing the Contractor unless otherwise directed by EOHHS.

b. Once all hospitals have established procedures for behavioral health crisis evaluations in medical or surgical inpatient and emergency department settings, as determined by EOHHS, the Contractor shall not make payments to Emergency Service Programs and Mobile Crisis Intervention teams for ED-based behavioral health crisis evaluations provided in the Emergency Department.

3. Behavioral Health Crisis Management (effective October 1, 2023)

The Contractor shall pay hospitals for behavioral health crisis management in medical or surgical inpatient and emergency department settings set forth in **Appendix C** in accordance with **Section 2.8.D.7.r**. Hospitals may sub-contract these services out to behavioral health providers, including crisis teams, but hospitals shall be solely responsible for billing the Contractor unless otherwise directed by EOHHS.

4. Effective October 1, 2023, the Contractor shall pay community-based AMCI and YMCI teams for a day of Adult or Youth Mobile Crisis Intervention services performed on the same day as a behavioral health crisis evaluation or behavioral health crisis management provided in a medical or surgical inpatient or emergency department setting as set forth in **Appendix C**, in accordance with **Section 2.8.D.7.a**."

20. **Section 2.13.D.4** is hereby amended by deleting and replacing "5" with "10".

21. **Section 2.14.C.1.a.1** is hereby amended by inserting "any required" after "inclusive of" and inserting "and determine" after "calculate".

22. **Section 2.15.C.1.c** is hereby amended by inserting at the end of the first paragraph "The Contractor shall continue updating data for previous months as received, but in no case for less than 18 months, regardless of the end of the Contract or a subcontract with a PBM."

23. **Section 2.21.C.2** is hereby amended by deleting **Section 2.21.C.2.i** in its entirety.

24. **Section 2.21.G** is hereby amended by deleting **Section 2.21.G** in its entirety and inserting in place thereof the following:

"G. National Committee on Quality Assurance (NCQA) Health Equity Accreditation

For any Contractor holding more than one ACPP and/or MCO contract with EOHHS, the Contractor shall:

1. By end of Contract Year 3, be accredited by the National Committee on Quality Assurance (NCQA) for its Health Equity Accreditation program at the Contractor level;

2. In Contract Years 1 and 2, the Contractor shall submit attestation of intent to achieve NQCA Health Equity Accreditation at the Contractor level by the end of Contract Year 3, in a form and format to be further specified by EOHHS;

3. Annually, inform EOHHS if it is nationally accredited through NCQA or if it has sought and been denied such accreditation;

4. As directed by EOHHS, submit a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any to EOHHS; and

5. Authorize NCQA to provide EOHHS a copy of the Contractor's most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings, and expiration date of accreditation."

25. **Section 4** is hereby amended by deleting "Health Equity Incentive" in each instance in which it occurs and inserting in place thereof the following: "Quality and Equity Incentive Program".

26. **Section 4.4.A** is hereby amended by deleting ";" at the end of **Section 4.4.A.2** and inserting in place thereof the following:

    ". Such annual reconciliations shall account for enrollment discrepancies related to Enrollees who have not resided in Massachusetts according to an EOHHS-specified federal report and Enrollees who have become deceased. The Contractor shall work with EOHHS to resolve any discrepancies in any calculations;"

27. **Section 4.4** is hereby amended by inserting a new **Section 4.4.D** as follows:

    "D. Miscellaneous

    As further specified by EOHHS, EOHHS shall perform a reconciliation for payments made by EOHHS for claims submitted to EOHHS between April 1, 2023, and May 31, 2023, for MCO Covered Services. EOHHS shall identify through such reconciliation the amount owed to EOHHS by the Contractor. The Contractor shall remit to EOHHS the full amount through recoupment from future capitation payments."

28. **Section 4.6.B** is hereby amended by deleting **Section 4.6.B.1** in its entirety and inserting a new **Section 4.6.B.1** as follows:

    "1. EOHHS shall pay the Contractor a payment based on the Contractor's Quality Score described in as set forth in **Appendix Q**. Such payment shall equal no more than 0.75 percent of the product of: by Region and Rating Category, the Contractor's Core Medical component of the Base Capitation Rate, for the

Contract Year, as set forth in **Appendix D**, per member, per month; the Contractor's experienced member months for the Contract Year as determined by EOHHS; and the Contractor's concurrent risk scores."

29. **Section 5** is hereby amended by deleting "Health Equity Incentive" in each instance in which it occurs and inserting in place thereof the following: "Quality and Equity Incentive Program" in each instance it occurs.

30. **Section 5.6.A.2** is hereby amended by deleting **Section 5.6.A.2.g** in its entirety and inserting a new **Section 5.6.A.2.g** as follows:

    "g. EOHHS may terminate this Contract with written notice if, in EOHHS' sole determination, the Contractor has signification programmatic cause for exit, as described in **Section 5.6.E**."

31. **Section 5.6.E** is hereby amended by deleting **Section 5.6.E.2** in its entirety and inserting a new **Section 5.6.E.2** as follows:

    "2. Programmatic Cause for Exit

        a. EOHHS may terminate this Contract if, in EOHHS' sole determination, the Contractor has significant programmatic cause for exist, as further specified by EOHHS;

        b. The Contractor may request a finding of significant programmatic cause for exit at any time by submitting a written request to EOHHS, in a form and format specified by EOHHS. The Contractor shall provide any additional information requested related to the request;

        c. EOHHS may, but is not obligated to, find significant programmatic cause for exit for the following reasons:

            1) Losses greater than 5% of the Risk Adjusted Capitation Payment in the last two recently completed Contract Years;

            2) The Contractor or its Network PCPs have merged with another MCO in the MassHealth MCO program."

32. **Appendix A, MCO Reporting Requirements**, is hereby deleted and replaced with the attached **Appendix A.**

33. **Appendix C, MCO Covered Services**, is hereby deleted and replaced with the attached **Appendix C**.

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

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

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

37. **Appendix Q, MCO Quality and Health Equity Appendix**, is hereby deleted and replaced with the attached **Appendix Q**.

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

39. **Attachment 1, Special Kids Special Care Program,** is hereby deleted and replaced with the attached **Attachment 1.**

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	Secure Email
CM-05	**CM-05 Updated Provider Directory** Provider Directory	Ad-Hoc	OnBase
CM-06	**CM-06 Provider Manual** Provider Manual	Ad-Hoc	OnBase
CM-07	**CM-07 Marketing Materials** Marketing Materials *(60 days in advance of use, including materials to be distributed at Contractor and non-Contractor sponsored health fairs or community events)*	Ad-Hoc	Secure Email
CM-08	**CM-08 Marketing Materials- Annual Executive Summary** Marketing Materials- Annual Executive Summary (including a written statement that all of the Contractor's marketing plans and materials are accurate and do not mislead, confuse, or defraud Members or the state)	Annually	OnBase
CM-09	**CM-09 Significant Changes in Provider Network Notification** Significant Changes in Provider Network Notification. (Notification: Same Day)	Ad-Hoc	OnBase
CM-10 [all]	**[RETIRED]**		

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-11	**CM-11 Access and Availability-Immediate Notification** Access and Availability-Immediate Notification to EOHHS (only if changes occur that may impact Enrollee access to care, relative to contract standards for geographic access and PCP to enrollee ratio)	Ad-Hoc	OnBase
CM-12	**CM-12 Claims Processing Report** Claims Processing Report	Monthly	OnBase
CM-13	**CM-13 Provider Financial Audit** Provider Financial Audit	Annually	OnBase
CM-14	**[RETIRED]**		
CM-15	**CM-15 Notification of Scheduled Board of Hearing Cases** Notification of Board of Hearing Cases (Notification: Same Day)	Ad-Hoc	OnBase and secure e-mail
CM-16	**CM-16 Implementation of Board of Hearing Decision** Implementation of Board of Hearing Decision (within 30 days of receipt)	Ad-Hoc	OnBase
CM-17-A	**CM-17-A Enrollee Inquiries Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Inquiries	Annually	OnBase
CM-17-B	**CM-17-B Enrollee Grievances Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Grievances	Annually	OnBase
CM-17-C	**CM-17-C Enrollee Internal Appeals Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee Internal Appeals	Annually	OnBase
CM-17-D	**CM-17-D Enrollee Board of Hearing Appeals Summary** Inquiries, Grievances, Internal Appeals and Board of Hearing Summary: Enrollee BOH Appeals	Annually	OnBase
CM-17-E	**CM-17-E - Appeals Report (per 1,000 Enrollees)** Appeals Report (per 1,000 Enrollees)	Monthly	OnBase
CM-17-F	**CM-17-F - Grievances Report (per 1,000 Enrollees)** Grievances Report (per 1,000 Enrollees)	Monthly	OnBase
CM-18	**[RETIRED]**		
CM-19	**[RETIRED]**		
CM-20	**[RETIRED]**		

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-21	**[RETIRED]**		
CM-22	**CM-22 ACO/MCO Organization and Key Personnel Changes** Organization and Key Personnel Changes. The Contractor will also include Behavioral Health subcontractor information if applicable.	Ad-Hoc	OnBase
CM-23	**CM-23 Notification of Termination of Material Subcontractor** Notification of Intention to Terminate a Material Subcontractor (Notification: Same Day)	Ad-Hoc	OnBase
CM-24	**CM-24 Notification of New Material Subcontractor and Checklist** Notification of Intention to Use a New Material Subcontractor and Checklist (Material Subcontract Checklist must be submitted no later than 60 days prior to requested implementation date)	Ad-Hoc	OnBase
CM-25	**CM-25 Material Subcontractor List Annual Summary** Material Subcontractor List Annual Summary	Annually	OnBase
CM-26	**CM-26 Coordination of Benefits / Third Party Liability Report (Appendix H)** Coordination of Benefits / Third Party Liability Report (Appendix H) a. Third Party Health Insurance Cost Avoidance Claims Amount by Carrier b. Third Party Health Insurance Total Recovery Savings by Carrier c. Accident Trauma Recoveries d. Accident/Trauma Cost Avoidance.	Semi-Annually	OnBase
CM-27	**CM-27 Third Party Liability (TPL) Identification Reporting (Appendix H)** 1. TPL Indicator Form 2. Other EOHHS-specified electronic TPL reporting	Ad-Hoc	1. Mail or Fax (FPL Indicator Form only) 2. Electronic Submission as further specified by EOHHS
CM-28	**CM-28 Benefits Coordination Structure (Appendix H)** Benefits Coordination Structure (Appendix H)	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-29	**CM-29 Encounter Data Submission (Appendix E)** Encounter Data Submission (Appendix E)	Monthly	Data Warehouse
CM-30	**CM-30 Sampling of Enrollees To Ensure Services Received** Sampling of Enrollees To Ensure Services Received Were The Same as Providers Billed	Annually	OnBase
CM-31	**CM-31 Notification of Federally Required Disclosures** Notification of Federally Required Disclosures (in accordance with Section 5.1.O)	Ad-Hoc	OnBase
CM-32	**CM-32 Notification of Reportable Findings /Network FRD** Notification of Reportable Findings /Network FRD (Notification: Same Day)	Ad-Hoc	OnBase
CM-33	**CM-33 Summary of Reportable Findings/Network FRD Forms** Summary of Reportable Findings/Network FRD Forms	Annually	OnBase
CM-34	**[RETIRED]**		
CM-35	**[RETIRED]**		
CM-36	**CM-36 Provider Materials** Provider Materials (related to enrollee cost-sharing, changes to Covered Services and/or any other significant changes per contractual requirements)	Ad-Hoc	OnBase
CM-37	**CM-37 ACO/MCO Policies and Procedures** ACO/MCO Policies and Procedures (New drafts and any changes to the most recent printed and electronic versions of the Provider procedures and policies which affect the process by which Enrollees receive care (relating to both medical health and Behavioral Health, if separate) for prior review and approval).	Ad-Hoc	OnBase
CM-38	**[RETIRED]**		
CM-39	**CM-39 PCP/Enrollee assignment Monthly report** PCP/Enrollee assignment report	Monthly	Data Warehouse
CM-40	**CM-40 PCP/Enrollee assignment report Ad-Hoc** PCP/Enrollee assignment report	Ad-hoc	Data Warehouse
CM-41	**CM-41 Excluded Provider Monitoring Report** Excluded Provider Monitoring Report	Monthly	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-43-A	**CM-43-A Holiday Closures and Other Contractor Office Closures Annual** Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annually	OnBase
CM-43-B	**CM-43-B Emergency Closures and Other Contractor Office Closures Ad Hoc** Emergency Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Ad Hoc	OnBase
CM-44	**CM-44 Strategy-related Reports** Strategy-related Reports	Ad Hoc	OnBase
CM-45	**[RETIRED]**		
CM-46	**CM-46 Enrollee and Provider Incentives Notification** Enrollee and Provider Incentives Notification	Ad-Hoc	OnBase
CM-47	**[RETIRED]**		
CM-48	**CM-48 Copy of Press Releases (pertaining to MassHealth line of business)** Copy of Press Releases (pertaining to MassHealth line of business)	Ad-Hoc	OnBase
CM-49	**CM-49 Written Disclosure of Identified Prohibited Affiliations** Written Disclosure of Identified Prohibited Affiliations	Ad-Hoc	OnBase
CM-50	**[RETIRED]**		
CM-51	**[RETIRED]**		
CM-52	**[RETIRED]**		
CM-53	**CM-53 Involuntary Change in PCP Report** Involuntary Change in PCP Report	Ad-Hoc	OnBase
CM-54-A	**CM-54-A Hospital Payment Arrangement Report** Hospital Payment Arrangement Report	Annually	OnBase
CM-54-B	**CM-54-B Hospital Fee Schedule Exemption Form** Hospital Fee Schedule Exemption Form	Ad-Hoc	OnBase
CM-55-A	**CM-55-A Summary of A&A: Ensuring Enrollees access to Medically Necessary services** Summary of Access and Availability: Description of Ensuring Enrollees have access to Medically Necessary services	Annually	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-55-A-ADH	**CM-55-A-ADH Summary of A&A: Ensuring Enrollees access to Medically Necessary services** Summary of Access and Availability: Description of Ensuring Enrollees have access to Medically Necessary services	Ad-Hoc	OnBase
CM-55-B	**CM-55-B Network Provider Lists: PCPs and OB/GYNs** Network Provider Lists: PCPs and OB/GYNs	Annually	OnBase
CM-55-B-ADH	**CM-55-B-ADH Network Provider Lists: PCPs and OB/GYNs** Network Provider List: PCPs and OB/GYNs	Ad-Hoc	OnBase
CM-55-C	**CM-55-C Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers** Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers	Annually	OnBase
CM-55-C-ADH	**CM-55-C-ADH Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers** Network Provider Lists: Acute and Rehabilitation Hospitals and Urgent Care Centers	Ad-Hoc	OnBase
CM-55-D	**CM-55-D Network Provider Lists: Physician Specialists** Network Provider Lists: Physician Specialists	Annually	OnBase
CM-55-D-ADH	**CM-55-D-ADH Network Provider Lists: Physician Specialists** Network Provider Lists: Physician Specialists	Ad-Hoc	OnBase
CM-55-E	**CM-55-E Network Provider List: Pharmacies** Network Provider List: Pharmacies	Annually	OnBase
CM-55-E-ADH	**CM-55-E-ADH Network Provider List: Pharmacies** Network Provider List: Pharmacies	Ad-Hoc	OnBase
CM-55-F	**CM-55-F Ratio Reports: PCP to Enrollee and OBGYN to Enrollee (female members age 10+)** Showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees/OBGYN ratios for female members age 10+)	Annually	OnBase
CM-55-F-ADH	**CM-55-F-ADH Ratio Reports: PCP to Enrollee and OBGYN to Enrollee (female members age 10+)** Showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees/OBGYN ratios for female members age 10+)	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-55-G	**CM-55-G Ratio Reports: Specialist to Enrollee** Specialists to Enrollee Ratio	Annually	OnBase
CM-55-G-ADH	**CM-55-G-ADH Ratio Reports: Specialist to Enrollee** Specialists to Enrollee Ratio	Ad-Hoc	OnBase
CM-55-H	**CM-55H Distance and time reports: PCP and OBGYN provider** Distance and time reports: PCP and OBGYN provider	Annually	OnBase
CM-55-H-ADH	**CM-55-H-ADH Distance and time reports: PCP and OBGYN provider** Distance and time reports: PCP and OBGYN provider	Ad-Hoc	OnBase
CM-55-I	**CM-55-I Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers** Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers	Annually	OnBase
CM-55-I-ADH	**CM-55-I-ADH Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers** Distance and time reports: Acute and Rehabilitation Hospitals and Urgent Care Centers	Ad-Hoc	OnBase
CM-55-J	**CM-55-J Distance and time reports: Physician Specialists** Distance and time reports: Physician Specialists	Annually	OnBase
CM-55-J-ADH	**CM-55-J-ADH Distance and time reports: Physician Specialists** Distance and time reports: Physician Specialists	Ad-Hoc	OnBase
CM-55-K	**CM-55-K Distance and time reports: Pharmacies** Distance and time reports: Pharmacies	Annually	OnBase
CM-55-K-ADH	**CM-55-K-ADH Distance and time reports: Pharmacies** Distance and time reports: Pharmacies	Ad-Hoc	OnBase
CM-55-L	**CM-55-L Timeliness of Care** Summary of Access and Availability: Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards)	Monthly	OnBase
CM-55-L-ADH	**CM-55-L-ADH Timeliness of Care** Summary of Access and Availability: Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards)	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-55-M	**CM-55-M Use of Out-of- Network Providers** Summary of Access and Availability: Use of Out-of- Network Providers	Annually	OnBase
CM-55-M-ADH	**CM-55-M-ADH Use of Out-of- Network Providers** Summary of Access and Availability: Use of Out-of- Network Providers	Ad-Hoc	OnBase
CM-56	**CM-56 CMS Managed Care Program Annual Report (MCPAR)** CMS Managed Care Program Annual Report (MCPAR)	Annually	OnBase
CM-57	**[RETIRED]**		
CM-58	**CM-58 Application for MassHealth Data [for External Research Projects]** Application for MassHealth Data	Ad-Hoc	Email
CM-59	**CM-59 Provider Enrollment True Up File** Provider Enrollment True Up File	Monthly	SFTP
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annually	OnBase
CM-C2	**CM-C2 Supplier Diversity Program (SDP) Spending Report for Prime Contractors** The SDP Spending Report form may be found here: https://www.mass.gov/lists/sdo-forms	Quarterly	Secure Email to assigned Contract Manager

C. 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	Annually	OnBase
BH-03	**BH-03 Behavioral Health Readmission Rates**	Annually	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Behavioral Health Readmission Rates		
BH-04	**BH-04 Behavioral Health Ambulatory Continuing Care Rates** Behavioral Health Ambulatory Continuing Care Rates	Annually	OnBase
BH-05	**BH-05 Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status.** Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status.	Daily	MABHA Website
BH-06	**BH-06 Enrollee Access to ESP** Enrollee Access to ESP	Ad hoc	OnBase
BH-08	**[RETIRED]**		
BH-11	**BH-11 Behavioral Health Medical Records Review Report** Behavioral Health Medical Records Review Report	Annually	OnBase
BH-12	**BH-12 Annually Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria** Annual Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria	Annually	OnBase
BH-13	**BH-13 Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report** Behavioral Health Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report	Quarterly	OnBase
BH-14	**BH-14 CANS Compliance Report** CANS Compliance. This report is required when CANS data is made available through the Virtual Gateway	Quarterly	OnBase
BH-15	**BH-15 Behavioral Health Utilization and Cost Report** Behavioral Health Utilization and Cost Report	Quarterly	OnBase
BH-17	**BH-17 Behavioral Health Inquiries, Grievances, Internal Appeals and BOH** Behavioral Health Inquiries, Grievances, Internal Appeals and BOH	Annually	OnBase
BH-18	**BH-18 Behavioral Health Provider Network Access and Availability** Behavioral Health Provider Network Access and Availability	Ad-hoc and Annually	OnBase
BH-19	**BH-19 Behavioral Health Telephone Statistics**	Annually	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Behavioral Health Telephone Statistics		
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	**[RETIRED]**		
BH-24	**BH-24 Community Support Program for Homeless Individuals Provider List** Community Support Program for Homeless Individuals Provider List	Annually	OnBase
BH-25	**BH-24 Community Support Program for Individuals with Justice Involvement Provider List** Community Support Program for Individuals with Justice Involvement Provider List	Quarterly	OnBase
BH-26	**BH-26: Community Support Program Tenancy Preservation Program Provider List** Community Support Program Tenancy Preservation Program Provider List	Annually	OnBase

D. Care Coordination

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CC-01	**CC-01 Care Needs Screening** Aggregate Care Needs Screening Completion Rates	Ad-hoc	OnBase
CC-02	**CC-02 HRSN Screening** HRSN Screening	Ad-hoc	OnBase
CC-03	**CC-03 HRSN Referrals** HRSN Referrals	Ad-hoc	OnBase
CC-04	**CC-04 Risk Stratification Algorithm** Risk Stratification Algorithm and Narrative	Annually	OnBase
CC-05	**CC-05 Care Management Program Descriptions and Performance** Care Management Program Descriptions and Performance	Annually	OnBase
CC-06	**CC-06 CP Performance Management**	Annually	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Summary of the Contractor's performance management strategy of the CP Program and overview of Contractor's CP Program performance.		
CC-07-A	**CC-7-A CP Quality Payment Receipts** CP Quality Payment Receipts	Annually	SFTP
CC-07-B	**CC-07-B CP Monthly Payment Receipts** CP Monthly Care Coordination Payment Receipts	Monthly	SFTP
CC-07-C	**CC-07-C CP Annual Payment Report** CP Annual Care Coordination Payment Report	Annually	SFTP
CC-08	**CC-08 Early warning indicators of performance concerns, CP Performance and/or Corrective Action Plans** As described in Section 2.6.E.3.b-c, notification within 5 business days of early warning indicators of CP performance concerns, and/or implementation of Performance Improvement Plans, and/or development of Corrective Action Plans	Ad hoc	OnBase
CC-9	**CC-9 Comprehensive Assessment and Care Plans (CM)** Comprehensive Assessment and Care Plan Completion Rates for Care Management	Ad hoc	OnBase
CC-10	**CC-10 Care Management Enrollment** Care Management Enrollment	Monthly	SFTP
CC-11	**CC-11 Care Management Program Budget** Care Management Program Budget	Annual	OnBase

E. Financial Reports

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	Annually	OnBase
FR-03	**FR-03 Financial Ratio Analysis** Financial Ratio Analysis\	Annually	OnBase
FR-04B	**FR-04B Experience Review and Revenue Expense Report (F-4B)** Experience Review and Revenue Expense Report (F-4B)	Quarterly and Annually	OnBase
FR-05C	**FR-05C Experience Review and Utilization/Cost Reports (F-5C)** Experience Review and Utilization/Cost Reports (F-5C)	Quarterly and Annually	OnBase
FR-07	**FR-07 Liability Protection Policies** Liability Protection Policies	Annually	OnBase
FR-08	**FR-08 DOI Financial Report (for Plans that are DOI licensed)** DOI Financial Report (for Plans that are DOI licensed)	Quarterly	OnBase
FR-09	**FR-09 Insolvency Reserves** Insolvency Reserves Attestation	Annually	OnBase
FR-10	**FR-10 Lag Triangles and Completion Factors Report (IBNR)** Lag Triangles and Completion Factors Report (IBNR)	Quarterly and Annually	OnBase
FR-11	**FR-11 Description of Incurred But Not Reported (IBNR) Methodology** Description of Incurred But Not Reported (IBNR) Methodology	Annually	OnBase
FR-12	**FR-12 Audited Financial Statements**	Annually	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Audited Financial Statements		
FR-13	**FR-13 Attestation Report from Independent Auditors on Effectiveness of Internal Controls** Attestation Report from Independent Auditors on Effectiveness of Internal Controls	Annually	OnBase
FR-14	**FR-14 Financial Relationships Report** Financial Relationships Report	Annually	OnBase
FR-15	**FR-15 Annual Administrative Detail Report** Annual Administrative Detail Report	Annually	OnBase
FR-17	**FR-17 Quarterly Risk Share Report** Quarterly Annual Risk Share Report	Quarterly and Annually	OnBase
FR-18-A	**[RETIRED]**		
FR-18-B	**[RETIRED]**		
FR-19	**FR-19 Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year** Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year	Ad-Hoc	OnBase
FR-20	**[RETIRED]**		
FR-21	**[RETIRED]**		
FR-22	**[RETIRED]**		
FR-23	**FR-23 Ad Hoc Cash Flow Statement** Ad Hoc Cash Flow Statement	Ad-Hoc	OnBase
FR-24	**FR-24 Report on Any Default of the Contractor's Obligations OR Financial Obligation To A Third Party.** Under This Contract, Or Any Default By A Parent Corporation On Any Financial Obligation To A Third Party That Could In Any Way Affect The Contractor's Ability To Satisfy Its Payment Or Performance Obligations. (Notification should be given Same Day)	Ad-Hoc	OnBase
FR-25	**FR-25 Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures** Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures That May Impact Performance	Ad-Hoc No later than 30 days prior to execution	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	(No later than 30 days prior to execution)		
FR-26	**FR-26 Provider Risk Arrangements** Provider Risk Arrangements	Ad-Hoc	OnBase
FR-27	**FR-27 Changes in Contractor's Providers' Risk Arrangements** Changes in Contractor's Providers' Risk Arrangements (Notification: Same Day)	Ad-Hoc	OnBase
FR-28	**FR-28 Working Capital Requirement Notification** Working Capital Requirement Notification ("if" working capital falls below 75% below the amount reported on the prior year audited financial reports) (Two Business Days)	Ad-Hoc	OnBase
FR-29	**FR-29 Continuing Services Reconciliation Data** Continuing Services Reconciliation Data	Ad-Hoc	OnBase
FR-30	**FR-30 ABA Reconciliation Report** ABA Reconciliation Report	Annually	OnBase
FR-31	**FR-31 Medical Loss Ratio (MLR) Report** Medical Loss Ratio (MLR) Report	Annually	OnBase
FR-32	**FR-32 Alternative Payment Models (APM) Report** Alternative Payment Models (APM) Report	Quarterly	OnBase
FR-33	**FR-33 Provider Agreements Annual** Provider Agreements Annual	Annually	OnBase
FR-34	**FR-34 Provider Agreements – Ad-Hoc** Provider Agreements – Ad-Hoc	Ad-Hoc	OnBase
FR-35	**FR-35 Report on Satisfying Contractor's Payment Or Performance Obligations** Report on Satisfying Contractor's Payment Or Performance Obligations	Ad-Hoc	OnBase
FR-37	**FR-37 IMD Services Report** Report on services provided to members with long term IMD stay	Quarterly and Annually	OnBase
FR-38	**FR-38 Other High Cost Pharmacy Reconciliation Report**	Annually	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Annual Other High Cost Pharmacy Risk Share Report		
FR-39	**FR-39 SUD Reconciliation Report** Annual SUD Risk Share Report	Annually	OnBase
FR-40	**FR-40 Financial Encounter Validation Report** Quarterly Financial Encounter Validation Report	Quarterly and Annually	OnBase
FR-41	**[RETIRED]**		
FR-42	**[RETIRED]**		
FR-44	**[RETIRED]**		

F. MCO Health Equity Reporting

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

G. Operations Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
OP-01	**[RETIRED]**		POSC
OP-02	**OP-02 Inbound Managed Care Provider Directory Interface (ACPD)** Inbound Managed Care Provider Directory Interface (ACPD)	Monthly	POSC
OP-03	**OP-03 Long-term Care Report Log** Long-term Care Report Log	Weekly	OnBase
OP-04	**OP-04 Member Discrepancy Report** Member Discrepancy Report	Monthly	OnBase
OP-05	[**RETIRED**]		
OP-06	**OP-06 Address Change File** Address Change File	Bi-Weekly	OnBase
OP-07	**OP-07 Multiple ID File**	Bi-Weekly	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Multiple ID File		
OP-08	**OP-08 Date of Death Report** Date of Death Report	Bi-Weekly	OnBase
OP-09	**OP-09 Cost Sharing Copay Overage Report** Cost Sharing Copay Overage Report	Monthly	OnBase

H. Pharmacy Reports

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	**[RETIRED]**		
PH-03	**PH-03 Pharmacy Provider Network Identification Layout** Pharmacy Provider Network Identification Layout	Ad-Hoc	POPS Portal
PH-04-A	**PH-04-A Drug Utilization Review Report** Drug Utilization Review Report *(Note: Due by May 1st of each year)*	Annually	Secure Email
PH-04-B	**[RETIRED]**		
PH-04-C	**[RETIRED]**		
PH-05-A	**PH-05-A Pharmacy MassHealth Drug Rebate File Submission Report** Pharmacy MassHealth Drug Rebate File Submission Report for the plans to self- report monthly on the upload of the report PH-01 to the POPS Portal. The File Submission Report is due within 3 business days following the upload of PH-01.	Monthly	Email
PH-05-B	**[RETIRED]**		
PH-06	**[RETIRED]**		
PH-07	**PH-07 Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal** Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal	Ad-Hoc	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-08	**PH-08 Clinical Policy Initiative Report** Clinical Policy Initiative Report	Ad-Hoc	OnBase
PH-09	**[RETIRED]**		
PH-10	**PH-10 Hepatitis C Utilization Report** Hepatitis C Utilization Report	Ad-Hoc	OnBase
PH-11	**PH-11 Pediatric BH Medication Initiative Report** Pediatric BH Medication Initiative Report	Ad-Hoc	OnBase
PH-12-A	**PH-12-A PBM Pricing Report - Quarterly** PBM Pricing Report- Quarterly	Quarterly	POPS Portal, or as directed by EOHHS
PH-12-B	**PH-12-B PBM Pricing Report - Ad-Hoc** PBM Pricing Report- Ad-Hoc	Ad-Hoc	POPS Portal, or as directed by EOHHS
PH-13	**PH-13 Mail Order Pharmacy Program Report** Mail Order Pharmacy Program Report- Ad-Hoc	Ad-Hoc	OnBase
PH-14	**PH-14 Change in BIN/PCN/Group Number Report** Change in BIN/PCN/Group Number Report- Ad-Hoc *(Note: Due at least 30-days before new BIN/PCN/Group Number is effective)*	Ad-Hoc	OnBase
PH-15	**PH-15 Vitrakvi Monitoring Report** Vitrakvi Monitoring Report- Quarterly	Quarterly	OnBase
PH-16-A	**PH-16-A Zolgensma Monitoring Program- Quarterly** Zolgensma Monitoring Program- Quarterly	Quarterly	OnBase
PH-16-B	**PH-16-B Zolgensma Monitoring Program- Annual** Zolgensma Monitoring Program- Annual	Annually	OnBase
PH-17	**PH-17 CAR-T Monitoring Program** CAR-T Monitoring Program-Quarterly	Quarterly	OnBase

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PH-18	**PH-18 Controlled Substance Management Program Enrollees Leaving Health Plan** Controlled Substance Management Program Enrollees Leaving Health Plan- Monthly	Monthly	OnBase
PH-19	**PH-19 Givlaari Monitoring Program** Givlaari Monitoring Program – Annual *(Note: Due by the last business day of April each year)*	Annually	OnBase
PH-20	**[RETIRED]**		
PH-21	**[RETIRED]**		
PH-22-A	**PH-22-A 340B Contract Pharmacies -Annual** 340B Contract Pharmacies- Annual	Annually	OnBase
PH-22-B	**PH-22-B 340B Contract Pharmacies – Ad-Hoc** 340B Contract Pharmacies – Ad-Hoc	Ad-Hoc	OnBase
PH-23- A	**PH-23-A 340B Margin Usage -Annual** **340B Margin Usage**	Annually	OnBase
PH-23-B	**PH-23-B 340B Margin Usage- Ad-Hoc** 340B Margin Usage- Ad-Hoc	Ad-Hoc	OnBase
PH-24	**PH-24 Oxlumo Monitoring Program** Oxlumo Monitoring Program	Quarterly	OnBase
PH-25	**PH-25 Amyloidosis Therapies Monitoring Program** Amyloidosis Therapies Monitoring Program -Quarterly	Quarterly	OnBase
PH-26	**PH-26 Zynteglo Monitoring Program** Zynteglo Monitoring Program – Annual (*Note: Due by the last business day of April each year*)	Annually	OnBase
PH-27	**PH-27 Clinical Monitoring Program** Clinical Monitoring Program – Ad-Hoc	Ad-Hoc	OnBase

I. Program Integrity

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PI-01	**PI-01 Fraud and Abuse Notification (within 5 days) and Activities** Fraud and Abuse Notification (within 5 days) and Activities	Ad-Hoc	OnBase and e-mail
PI-02	**PI-02 Notification of For-Cause Provider Suspensions and Terminations** Notification of Provider Suspensions and Terminations	Notification: Within 3 Business Days	OnBase
PI-03	**PI-03 Summary Report of For-Cause Provider Suspensions and Terminations** Summary Report of Provider Suspensions and Terminations	Annual	OnBase
PI-04	**PI-04 Notification of Provider Overpayments** Notification of Provider Overpayments	Ad-hoc	OnBase
PI-05	**PI-05 Summary of Provider Overpayments** Summary of Provider Overpayments	Semi-annually	OnBase
PI-06	**PI-06 Response to Overpayments Identified by EOHHS Report** Response to Overpayments Identified by EOHHS Report	Ad-hoc	OnBase
PI-07	**PI-07 Agreed Upon Overpayments Collection Report** Agreed Upon Overpayments Collection Report	Ad-hoc	OnBase
PI-08	**PI-08 - Self-Reported Disclosures** Self-Reported Disclosures	Ad-Hoc	OnBase
PI-09	**PI-09 Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan** Program Integrity Compliance Plan and Anti-Fraud, Waste and Abuse Plan	Annual	OnBase
PI-10	**PI-10 Payment Suspension** Quarterly Payment Suspension Report	Quarterly	OnBase

J. Quality Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-01	**QR-01 QM/QI Program Description/Workplan** Report needs to be submitted as per Appendix B, Quality Improvement Goals.	Annually	OnBase
QR-02	**QR-02 CAHPS Reports (Submission of full CAHPS Report)** CAHPS Reports (Submission of full CAHPS Report as well Member-level and aggregate data made available via NCQA submission process)	Annually, on July 31st	OnBase
QR-03	**[RETIRED]**		
QR-04	**QR-04 External Audit/Accreditation** External Accreditation (Submission of NCQA accreditation report and associated results)	Ad-Hoc	OnBase
QR-05	**QR-05 HEDIS IDSS Report** HEDIS IDSS Report (Submission in Excel and CSV formats).	Annually	OnBase
QR-06	**QR-06 HEDIS Member Level Data**	Annually	Email
QR-09	**QR-09 Validation of Performance Measures** Performance Measure Data (Format for submission determined and communicated by External Quality Review Organization).	Annually	EQRO
QR-10	**QR-10 Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)** Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs) (*including Health care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs) Submission using EOHHS developed template).*	Notification: Within 30 calendar days of occurrence	OnBase
QR-11	**QR-11 Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)** Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs) (Submission using EOHHS-developed template).	Annually	OnBase
QR-12	**QR-12 Performance Improvement Projects** Performance Improvement Project Reports (Format for submission determined by and communicated by External Quality Review Organization).	Bi-Annually	EQRO

APPENDIX C
Exhibit 1: MCO Covered Services
✓ Denotes a covered service

The Contractor shall provide to each Enrollee each of the MCO Covered Services listed below in an amount, duration, and scope that is Medically Necessary (as defined in **Section 1** of this Contract), provided that the Contractor is not obligated to provide any MCO Covered Service in excess of any service limitation expressly set forth below. Except to the extent that such service limitations are set forth below, the general descriptions below of MCO Covered Services do not limit the Contractor's obligation to provide all Medically Necessary services.

	Coverage Types			
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
Acupuncture Treatment - the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, for pain relief or anesthesia.	✓	✓	✓	✓
Acute Inpatient Hospital –all inpatient services such as daily physician intervention, surgery, obstetrics, radiology, laboratory, and other diagnostic and treatment procedures. Coverage of acute inpatient hospital services shall include Administratively Necessary Days. Administratively Necessary Day shall be defined as a day of Acute Inpatient Hospitalization on which an Enrollee's care needs can be provided in a setting other than an Acute Inpatient Hospital and on which an Enrollee is clinically ready for discharge.	✓	✓	✓	✓
Ambulatory Surgery/Outpatient Hospital Care - outpatient surgical, related diagnostic, medical and dental services.	✓	✓	✓	✓
Audiologist – audiologist exams and evaluations. See related hearing aid services.	✓	✓	✓	✓
Behavioral Health Services – see **Appendix C, Exhibit 3**.	✓	✓	✓	✓
Breast Pumps and Breast Milk Storage Bags – to expectant and new birthing parents as specifically prescribed by their attending physician, consistent with the provisions of the Affordable Care Act of 2010 and Section 274 of Chapter 165 of the Acts of 2014, including but not limited to double electric breast pumps one per birth or as medically necessary.	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Certain COVID-19 Specimen Collection and Testing – until May 11, 2023, Specimen collection codes G2023 and G2024 billed with modifier CG, used when provider 1) has a qualified ordering clinician present at the specimen collection site available to order medically necessary COVID-19 diagnostic tests; and 2) ensures the test results are provided to the patient (along with any initial follow-up counseling, as appropriate), either directly or through the patient's ordering clinician.	✓	✓	✓	✓
Chiropractic Services – The Contractor is responsible for providing chiropractic manipulative treatment, office visits, and radiology services for all Enrollees. The Contractor may establish a per Enrollee per Contract Year service limit of 20 office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments.	✓	✓	✓	✓
Chronic, Rehabilitation Hospital or Nursing Facility Services – services, for all levels of care, including for eligible Enrollees under the age of 22 in accordance with applicable state requirements, provided at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, 100 days per Contract Year per Enrollee The 100-day limitation shall not apply to Enrollees receiving Hospice services and the Contractor may not request disenrollment of Enrollees receiving Hospice services based on the length of time in a nursing facility. The Contractor shall use the following MassHealth admission/coverage criteria for admission into a chronic hospital, rehabilitation hospital and nursing facility, and may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts such 100-day limitation described above. For the applicable criteria, see 130 CMR 456.408, 456.409, 456.410 and 435.408, 435.409 and 435.410 (rehabilitation hospitals). In addition, for Enrollees under the age of 22, the Contractor shall ensure that its contracted nursing facilities comply with the relevant provisions of 105 CMR 150.000, et seq. The Contractor must ensure that its contracted nursing facilities establish and follow a written policy regarding its bed-hold period, consistent with the MassHealth bed-hold policy. For applicable criteria, see 130 CMR 456.425. For clarification purposes, an Enrollee's stay while recovering from COVID-19 in a nursing facility or chronic or rehabilitation hospital, or any combination	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
thereof, shall count towards the 100-day per Contract Year per Enrollee coverage described in this section; provided, however for an Enrollee's stays in a Commonwealth-designated COVID-19 nursing facility, see non-MCO Covered Services in Exhibit 2 below.				
Dental - Emergency related dental services as described under Emergency Services in **Appendix C, Exhibit 1** and oral surgery which is Medically Necessary to treat a medical condition performed in any place of service, including but not limited to an outpatient setting, as described in Ambulatory Surgery/Outpatient Hospital Care in **Appendix C, Exhibit 1** as well as a clinic or office settings.	✓	✓	✓	✓
Diabetes Self-Management Training – diabetes self-management training and education services furnished to an individual with pre-diabetes or diabetes by a physician or certain accredited mid-level providers (e.g., registered nurses, physician assistants, nurse practitioners, and licensed dieticians).	✓	✓	✓	✓
Dialysis – laboratory; prescribed drugs; tubing change; adapter change; and training related to hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis.	✓	✓	✓	✓
Durable Medical Equipment and Medical/Surgical Supplies – **1) Durable Medical Equipment** - products that: (a) are fabricated primarily and customarily to fulfill a medical purpose; (b) are generally not useful in the absence of illness or injury; (c) can withstand repeated use over an extended period of time; and (d) are appropriate for home use. Includes but not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, & rentals), walkers, commodes, special beds, monitoring equipment, and the rental of Personal Emergency Response Systems (PERS). **2) Medical/Surgical Supplies** - medical/treatment products that: (a) are fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) are used in the treatment of a specific medical condition; and (c) are non-reusable and	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
disposable including, but not limited to, items such as urinary catheters, wound dressings, and diapers.				
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services – Children, adolescents and young adults who are under 21 years old and are enrolled in MassHealth Standard and CommonHealth are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including Medically Necessary services that are listed in 42 U.S.C. 1396d(a) and (r) and discovered as a result of a medical screening.	✓			✓
Early Intervention –child visits, center-based individual visits, community child group, early intervention-only child group, and parent-focused group sessions; evaluation/assessments; and intake/screenings. The Contractor may establish a service limit restricting Early Intervention Services to Enrollees aged 3 or under.	✓	✓		✓
Emergency Services – covered inpatient and outpatient services, including Behavioral Health Services, which are furnished to an Enrollee by a provider that is qualified to furnish such services under Title XIX of the Social Security Act, and needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.	✓	✓	✓	✓
Family Planning – family planning medical services, family planning counseling services, follow-up health care, outreach, and community education. Under Federal law, an Enrollee may obtain family planning services from any MassHealth provider of family planning services without the Contractor's authorization.	✓	✓	✓	✓
Fluoride Varnish – Pediatricians and other qualified health care professionals (Physician Assistants, Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses) may apply Fluoride Varnish to eligible MassHealth Enrollees under age 21, during a pediatric preventive care visit. This service is primarily intended for children 0-6 but may be covered up to age 21.	✓	✓		✓
Hearing Aids – The Contractor is responsible for providing and dispensing hearing aids; ear molds; ear impressions; batteries; accessories; aid and instruction in the use, care, and maintenance of the hearing aid; and loan of a hearing aid to the Enrollee, when necessary.	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Home Health Services – skilled and supportive care services provided in the member's home to meet skilled care needs and associated activities of daily living to allow the member to safely stay in their home. Available services include skilled nursing, medication administration, home health aide, and occupational, physical, and speech/language therapy. See CMR 403.000 and MassHealth Home Health Agency Bulletin 54 (June 2019).	✓	✓	✓	✓
Hospice – a package of services designed to meet the needs of terminally ill patients such as nursing; medical social services; physician; counseling; physical, occupational and speech language therapy; homemaker/home health aide services; medical supplies, drugs and durable medical equipment and supplies, short term general inpatient care, short term respite care, and room and board in a nursing facility provided, however, that the 100 day limitation on institutional care services shall not apply to an Enrollee receiving Hospice services. Hospice services covered by the Contractor shall include room and board in a nursing facility pursuant to 130 CMR 437.424(B). Hospice is an all-inclusive benefit. The Enrollee has to elect the Hospice benefit and, by electing the Hospice benefit, the Enrollee waives their right to the otherwise independent services that are for the Enrollee included as a part of the Hospice benefit. If an Enrollee elects Hospice, then the Enrollee waives their rights for the duration of the election of hospice care for any services related to the treatment of the terminal condition for which hospice care was elected or that are equivalent to hospice care. However, Enrollees under age 21 who have elected the Hospice benefit shall have coverage for curative treatment and all Medically Necessary MCO and Non-MCO Covered Services for MassHealth Standard and CommonHealth Enrollees.	✓	✓	✓	✓
Infertility – Diagnosis of infertility and treatment of an underlying medical condition.	✓	✓	✓	✓
Laboratory – all services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Enrollees. All laboratories performing services under this Contract shall meet the credentialing requirements set forth in	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Section 2.9.H, including all medically necessary vaccines not covered by the Commonwealth of Massachusetts Department of Public Health.				
MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids – a service that provides targeted case management services for high risk individuals under age 21 with medical complexity. MassHealth CARES for Kids provides comprehensive, high-touch care coordination for children and their families. This service is provided in certain primary care or specialized settings where medically complex individuals under age 21 receive medical care. MassHealth CARES for Kids providers will serve as lead entities to coordinate prompt and individualized care across the health, educational, state agency, and social service systems.	✓			
Medical Nutritional Therapy – nutritional, diagnostic, therapy and counseling services for the purpose of a medical condition that are furnished by a physician, licensed dietician, licensed dietician/nutritionist, or other accredited mid-level providers (e.g., registered nurses, physician assistants, and nurse practitioners).	✓	✓	✓	✓
Orthotics – braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body. See Subchapter 6 of the Orthotics Manual.	✓	✓	✓	✓
Oxygen and Respiratory Therapy Equipment – ambulatory liquid oxygen systems and refills; aspirators; compressor-driven nebulizers; intermittent positive pressure breather (IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental.	✓	✓	✓	✓
Pharmacy – The Contractor is responsible for providing prescription, over-the-counter drugs, Non-Drug Pharmacy Products, and effective July 1, 2023, pharmaceutical compounded drugs as described below. **1) Prescription Drugs:** prescription drugs that are approved by the U.S. Food and Drug Administration. The Contractor may limit coverage to those drugs manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. §1396r-8.	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
2) **Over-the-Counter Drugs:** The Contractor may limit coverage to those drugs manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C.§1396r-8. Except with regard to insulin, the Contractor also may limit over-the-counter drugs for Enrollees aged 21 and over to those necessary for the life and safety of the Enrollee. 3) **Non-Drug Pharmacy Products**: non-drug pharmacy products as listed in the MassHealth Non-Drug Product List 4) **Pharmaceutical Compounded Drugs**: pharmaceutical compounded drugs as listed on the MassHealth Drug List				
Physician (primary and specialty) – all medical, developmental pediatrician, psychiatry, radiological, laboratory, anesthesia and surgical services, including those services provided by nurse practitioners serving as primary care providers and services provided by nurse midwives.	✓	✓	✓	✓
Podiatry – The Contractor is responsible for providing services as certified by a physician, including medical, radiological, surgical, and laboratory care. For restrictions regarding coverage of orthotics, see the "Orthotics" service description above.	✓	✓	✓	✓
Preventive Pediatric Health Screening and Diagnostic Services - children, adolescents and young adults who are under 21 years old and are enrolled in the MassHealth Basic, Essential or Family Assistance Plan are entitled to Preventive Pediatric Healthcare Screening and Diagnosis Services as outlined in 130 CMR 450.150.		✓		
Private Duty Nursing/Continuous Skilled Nursing – a nursing visit of more than two continuous hours of nursing services. This service can be provided by either a home health agency or Independent Nurse.				✓
Prosthetic Services and Devices – evaluation, fabrication, fitting, and the provision of a prosthesis. For individuals over age 21, certain limitations apply. See Subchapter 6 of the Prosthetics Manual	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Radiology and Diagnostic Tests – X-rays, portable X-rays, magnetic resonance imagery (MRI) and other radiological and diagnostic services, including those radiation or oncology services performed at radiation oncology centers (ROCs) which are independent of an acute outpatient hospital or physician service.	✓	✓	✓	✓
Remote Patient Monitoring (COVID-19 RPM) - bundled services to facilitate home monitoring of Enrollees with confirmed or suspected COVID-19 who do not require emergency department or hospital level of care but require continued close monitoring. The COVID-19 RPM bundle includes all medically necessary clinical services required to facilitate seven days of close, in-home, monitoring of members with confirmed or suspected COVID-19. Details around MassHealth's coverage of the RPM bundle can be found in All Provider Bulletin 294, as may be updated from time to time. The Contractor must cover the RPM bundle of services in the method and manner specified in All Provider Bulletin 294, as may be updated from time to time, when such services are delivered as Medicaid services. The Contractor may determine their own rate of payment for the RPM bundle of services.	✓	✓	✓	✓
School Based Health Center Services – all MCO Covered Services set forth in this Appendix C delivered in School Based Health Centers (SBHCs).	✓	✓		✓
Therapy – individual treatment, (including the design, fabrication, and fitting of an orthotic, prosthetic, or other assistive technology device); comprehensive evaluation; and group therapy. **1) Physical:** evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems. **2) Occupational:** evaluation and treatment designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. **3) Speech and Hearing:** evaluation and treatment of speech language, voice, hearing, and fluency disorders.	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Tobacco Cessation Services – face-to-face individual and group tobacco cessation counseling as defined at 130 CMR 433.435(B), 130 CMR 405.472 and 130 CMR 410.447 and pharmacotherapy treatment, including nicotine replacement therapy (NRT).	✓	✓	✓	✓
Transportation (emergent) – ambulance (air and land) transport that generally is not scheduled, but is needed on an Emergency basis, including Specialty Care Transport that is ambulance transport of a critically injured or ill Enrollee from one facility to another, requiring care that is beyond the scope of a paramedic.	✓	✓	✓	✓
Transportation (non-emergent, to out-of-state location) – ambulance and other common carriers that generally are pre-arranged to transport an Enrollee to a service that is located outside a 50-mile radius of the Massachusetts border.	✓		✓	✓
Urgent Care Clinic Services – MCO Covered Services set forth in this Appendix C provided by an urgent care clinic consistent with 130 CMR 455.000 and Section 39 of Ch. 260 of the Acts of 2020.	✓	✓	✓	✓
Vaccine Counseling Services	✓	✓	✓	✓
Vision Care (medical component) – eye examinations (a) once per 12-month period for Enrollees under the age of 21 and (b) once per 24-month period for Enrollees 21 and over, and, for all Enrollees, whenever Medically Necessary; vision training; ocular prosthesis; contacts, when medically necessary, as a medical treatment for a medical condition such as keratoconus; and bandage lenses.	✓	✓	✓	✓
Wigs – as prescribed by a physician related to a medical condition.	✓	✓	✓	✓

Appendix C

Exhibit 2: Non-MCO Covered Services

✓ Denotes a Non-MCO Covered Service (wrap service)

The Contractor need not provide, but shall coordinate, for each Enrollee the delivery of all MassHealth services (see 130 CMR 400.000 through 499.000) for which such Enrollee is eligible (see 130 CMR 450.105) but which are not currently MCO Covered Services. Coordination of such services shall include, but not be limited to, informing the Enrollee of the availability of such services and the processes for accessing those services. The general list and descriptions, below, of MassHealth services that are not MCO Covered Services do not constitute a limitation on the Contractor's obligation to coordinate all such services for each Enrollee eligible to receive those services.

	Coverage Types			
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
Abortion - includes, in addition to the procedure itself, pre-operative evaluation and examination; pre-operative counseling; laboratory services, including pregnancy testing, blood type, and Rh factor; Rh, (D) immune globulin (human); anesthesia (general or local); echography; and post-operative (follow-up) care. Abortion does not constitute a family planning service. The procedure itself is federally funded only in the following situations: (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. Such services may be provided in a physician's office, clinic, or hospital, subject to limitations imposed by applicable law and administrative and billing regulations.	✓	✓	✓	✓
Adult Dentures – full and partial dentures, and repairs to said dentures, for adults ages 21 and over.	✓	✓	✓	✓
Adult Day Health – services ordered by a physician and delivered to an Enrollee in a community-based program setting that is open at least Monday through Friday for eight hours per day and include: nursing and healthcare oversight, therapy, assistance with Activities of Daily Living (ADL), nutritional and dietary, counseling activities and case management. Services provided are based upon an individual plan of care.	✓			✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Transportation to and from the Adult Day Health program is arranged and reimbursed by the Adult Day Health program. In order to be eligible for Adult Day Health Services, the Enrollee must be at least 18 years of age or older and require assistance with at least one (1) ADL or one (1) skilled service and meet the eligibility criteria outlined in 130 CMR 404.407.				
Adult Foster Care - services ordered by a physician and delivered to an Enrollee in a home environment that meets the qualified setting as described in 130 CMR 408.435 Services are based upon an individual plan of care and include assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other personal care as needed, nursing services and oversight, and care management. Assistance with ADLs, IADLs and other personal care is provided by a qualified caregiver that lives with the Enrollee in the home environment. Nursing services and oversight and care management are provided by a multidisciplinary team. In order to be eligible for Adult Foster Care services, the Enrollee must be at least 16 years of age or older an require assistance with at least one (1) ADL and meet the eligibility criteria outlined in 130 CMR 408.417.	✓			✓
Chronic, Rehabilitation Hospital, or Nursing Facility Services – Both 1. Services provided at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, over 100 days per Contract Year per Enrollee; provided, however, that (A) for Enrollees receiving Hospice services, the Contractor shall cover skilled nursing facility services without limitation, and (B) for Enrollees in Family Assistance such coverage is limited to six months consistent with MassHealth policy; and 2. Any stay of any duration in a Commonwealth-designated COVID-19 nursing facility.	✓	✓		✓
Day Habilitation – services provided in a community based day program setting that is open at least Monday through Friday for six hours per day and includes daily programming based on activities and therapies necessary to meet individual goals and objectives. Goals and objectives are outlined on a day habilitation service plan and are	✓			✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
designed to help an Enrollee reach his/her optimal level of physical, cognitive, psychosocial and occupational capabilities. In order to be eligible for Day Habilitation services, the Enrollee must be at least 18 years of age or older; have a diagnosis of mental retardation and/or developmental disability; and meet the eligibility criteria outlined in 130 CMR 419.434.				
Dental - preventive and basic services for the prevention and control of dental diseases and the maintenance of oral health for children and adults as described in 130 CMR 420.000.	✓	✓	✓	✓
Group Adult Foster Care - services ordered by a physician delivered to an Enrollee in a group housing residential setting such as assisted living, elderly, subsidized or supportive housing. Group Adult Foster Care services are based upon an individual plan of care and include: assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other personal care as needed, nursing services and oversight and care management. Assistance with ADLs, IADLs and other personal care is provided by a direct care worker that is employed or contracted by the Group Adult Foster Care Provider, Nursing services and oversight and care management are provided by a multidisciplinary team. In order to be eligible for Group Adult Foster Care services, the Enrollee must be at least 22 years of age or older and require assistance with at least one (1) ADL.	✓			✓
Isolation and Recovery Site Services – services received by an Enrollee in an Isolation and Recovery site that are paid for by EOHHS using the payment methodologies described in Administrative Bulletin AB 20-30 or as set forth in the Acute Hospital RFA.	✓	✓	✓	✓
Personal Care Attendant – physical assistance with Activities of Daily Living (ADLs) such as: bathing, dressing/grooming, eating, mobility, toileting, medication administration, and passive range of motion exercise for Enrollees who have a chronic or permanent disability requiring physical assistance with two (2) or more ADLs. If an Enrollee is clinically eligible for PCA, an Enrollee may also receive assistance with Instrumental Activities of Daily Living (IADLs), including household management tasks, meal preparation, and transportation to medical providers.	✓			✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	**MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
Private Duty Nursing/Continuous Skilled Nursing – a nursing visit of more than two continuous hours of nursing services. This service can be provided by a home health agency, continuous skilled nursing agency, or Independent Nurse.	✓			
Transitional Support Services (TSS) for Substance Use Disorders (Level 3.1) – 24- hour short term intensive case management and psycho-educational residential programming with nursing available for members with substance use disorders who have recently been detoxified or stabilized and require additional transitional stabilization prior to placement in a residential or community based program. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.	✓	✓	✓	✓
Transportation (non-emergent, to in-state location or location within 50 miles of the Massachusetts border) - ambulance (land), chair car, taxi, and common carriers that generally are pre-arranged to transport an Enrollee to a covered service that is located in-state or within a 50-mile radius of the Massachusetts border.	✓		✓	✓
Vision Care (non-medical component) - prescription and dispensing of ophthalmic materials, including eyeglasses and other visual aids, excluding contacts.	✓	✓	✓	✓

Appendix C
Exhibit 3: MCO Covered Behavioral Health Services
✓ Denotes a covered service

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
Inpatient Services - 24-hour services, delivered in a licensed or state-operated hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both. This service does not include continuing inpatient psychiatric care delivered at a facility that provides such services, as further specified by EOHHS. **(See details below)**				
1. Inpatient Mental Health Services - hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability. Such services include (1) inpatient psychiatric services provided to Enrollees under the age of 21 with Autism Spectrum Disorder or Intellectual or Developmental Disability (ASD/IDD) in specialized ASD/IDD inpatient psychiatric settings; and (2) for dates of service on or after October 1, 2023, specialized inpatient psychiatric services provided to Enrollees with an eating disorder diagnosis and severe associated psychiatric and medical needs in specialized eating disorder psychiatric settings.	✓	✓	✓	✓
2. Inpatient Substance Use Disorder Services (Level 4) - Intensive inpatient services provided in a hospital setting, able to treat Enrollees with acute medically complex withdrawal management needs, as well as co-occurring biomedical and/or psychiatric conditions. Services are delivered by an interdisciplinary staff of addiction credentialed physician and other appropriate credentialed treatment professionals with the full resources of a general acute care or psychiatric hospital available.	✓	✓	✓	✓
3. Observation/Holding Beds - hospital services, for a period of up to 24 hours, in order to assess, stabilize, and identify appropriate resources for Enrollees.	✓	✓	✓	✓
4. Administratively Necessary Day (AND) Services - a day(s) of inpatient hospitalization provided to Enrollees when said Enrollees are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
Diversionary Services - those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services, those provided in a 24-hour facility, and those which are provided in a non-24-hour setting or facility. **(See detailed services below)**				
24-Hour Diversionary Services:				
a. Youth and Adult Community Crisis Stabilization – services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Enrollees who do not require Inpatient Services.	✓	✓	✓	✓
b. **Community-Based Acute Treatment for Children and Adolescents (CBAT)** – mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services.	✓	✓		✓
c. Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7) – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Withdrawal management services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; induction to FDA approved medications for addictions when appropriate, individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Enrollees with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
d. Clinical Support Services for Substance Use Disorders (Level 3.5) – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, including comprehensive bio-psychosocial assessments and treatment planning, therapeutic milieu, intensive psycho education and counseling, outreach to families and significant others, linkage to medications for addiction therapy, connection to primary care and community supports and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.	✓	✓	✓	✓
e. Transitional Care Unit (TCU) – A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The program serves children and adolescents, under age 19, who are in the custody of the Department of Children and Families (DCF), who have been determined to need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies**.**	✓	✓		✓
Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)				
a. Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour residential environment that provides a structured and comprehensive rehabilitative environment that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Residential programs licensed and approved to serve pregnant and post-partum women provide assessment and management of	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
gynecological and/or obstetric and other prenatal needs, as well as treatment plans addressing parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.				
b. Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour residential environment for families in which a parent has a substance use disorder and either is pregnant, has custody of at least one child or has a physical reunification plan with at least one child within 30 days of admission. Scheduled, goal-oriented rehabilitative services intended to support parents and children are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal and parenting skills necessary to lead an alcohol and/or drug-free lifestyle and support family reunification and stability. Enrollees receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities.	✓	✓	✓	✓
c. Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour developmentally appropriate residential environment designed specifically for either Transitional Age Youth ages 16-21 or Young Adults ages 18-25 that provides a structured and comprehensive rehabilitative environment for that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Enrollees receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
d. Youth Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour developmentally appropriate residential environment with enhanced staffing and support designed specifically for youth ages 13-17 that provides a structured and comprehensive rehabilitative environment for that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions.	✓	✓	✓	✓
e. Pregnancy Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) 24-hour developmentally appropriate residential environment designed specifically for people who are pregnant that provides a structured and comprehensive rehabilitative environment for that supports each resident's independence and resilience and recovery from alcohol and/or other drug problems. Scheduled, goal-oriented rehabilitative services are provided in conjunction with ongoing support and assistance for developing and maintaining interpersonal skills necessary to lead an alcohol and/or drug-free lifestyle. Members receive at least five hours of individual or group therapy each week in addition to case management, psychoeducation and milieu based rehabilitative activities. Residential programs must provide assessment and management of gynecological and/or obstetric and other prenatal needs, as well as treatment plans addressing parenting skills education, child development education, parent support, family planning, nutrition, as well as opportunities for parent/child relational and developmental groups.	✓	✓	✓	✓
f. Co-Occurring Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1) - 24-hour, safe, structured environment, located in the community, which supports Enrollee's recovery from addiction and moderate to severe mental health conditions while reintegrating into the community and returning to social, vocation/employment, and/or	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
educational roles. Scheduled, goal-oriented clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate. Programs will ensure that Members have access to prescribers of psychiatric and addiction medications.				
Non-24-Hour Diversionary Services				
a. **Community Support Program (CSP) and Specialized CSP** - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Enrollees with a long standing history of a psychiatric or substance use disorder and to their families, or to Enrollees who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee. Specialized CSP programs serve populations with particular needs. **Specialized CSP Programs:** **1. CSP for Justice Involved –** a Specialized CSP service to address the health-related social needs of Enrollees with Justice Involvement who have a barrier to accessing or consistently utilizing medical and behavioral health services, as defined by EOHHS. CSP-JI includes behavioral health and community tenure sustainment supports. 2. **CSP for Homeless Individuals –** a Specialized CSP service to address the health-related social needs of Enrollees who (1) are experiencing Homelessness and are frequent users of acute health MassHealth services, as defined by EOHHS, or (2) are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development. 3. **CSP – Tenancy Preservation Program -** a Specialized CSP service to address the health-related social needs of Enrollees who are At Risk of Homelessness and facing Eviction as a	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
result of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services in order to address the underlying issues causing the lease violation. The primary goal of the CSP-TPP is to preserve the tenancy and the secondary goals are to put in place services that address those issues that put the Enrollee's housing in jeopardy to ensure that the Enrollee's housing remains stable.				
b. Partial Hospitalization (PHP) – an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.	✓	✓	✓	✓
c. Psychiatric Day Treatment - services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.	✓	✓	✓	✓
d. Structured Outpatient Addiction Program (SOAP) - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24-hour monitoring.	✓	✓	✓	✓
e. Intensive Outpatient Program (IOP) - a clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.				
f. Recovery Coaching - a non-clinical service provided by individuals currently in recovery from a substance use disorder who have been certified as Recovery Coaches. Eligible Enrollees will be connected with Recovery Coaches at critical junctures in the Enrollees' treatment and recovery. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery, facilitate initiation and engagement to treatment and serve as a guide and motivating factor for the Enrollee to maintain recovery and community tenure.	✓	✓	✓	✓
g. Recovery Support Navigators - a specialized care coordination service intended to engage Enrollees with Substance Use Disorder in accessing and continuing Substance Use Disorder treatment. RSNs may be located in a variety of Substance Use Disorder treatment environments, as well as hospital medical or surgical inpatient and emergency department settings, doing outreach and building relationships with individuals in programs, including withdrawal management and step-down services. If an Enrollee accepts RSN services upon leaving a Substance Use Disorder treatment program, the RSN will work with the individual on accessing appropriate treatment and staying motivated for treatment and recovery. These services shall be provided in accordance with the MassHealth Acute Hospital Request for Applications (Acute Hospital RFA) when provided in hospital settings.	✓	✓	✓	✓
h. Program of Assertive Community Treatment (PACT) – a multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Enrollees to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
Outpatient Services - mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner's office. The services may be provided at an Enrollee's home or school. **(See detailed services below)**				
Standard Outpatient Services – those Outpatient Services most often provided in an ambulatory setting.				
a. Family Consultation - a meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the Enrollee and clinically relevant to an Enrollee's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.	✓	✓	✓	✓
b. Case Consultation - an in-person or by telephone meeting of at least 15 minutes' duration, between the treating Provider and other behavioral health clinicians or the Enrollee's primary care physician, concerning an Enrollee who is a client of the Provider, to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.	✓	✓	✓	✓
c. Diagnostic Evaluation - an assessment of an Enrollee's level of functioning, including physical, psychological, social, educational and environmental strengths and challenges for the purpose of diagnosis and designing a treatment plan.	✓	✓	✓	✓
d. Dialectical Behavioral Therapy (DBT) - a manual-directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and supportive psychotherapies for Enrollees with borderline personality disorder who also exhibit chronic, parasuicidal behaviors and adolescents who exhibit these symptoms. DBT may be used for other disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.	✓	✓	✓	✓
e. Psychiatric Consultation on an Inpatient Medical Unit - an in- person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.				
f. Medication Visit - an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.	✓	✓	✓	✓
g. Couples/Family Treatment - the use of psychotherapeutic and counseling techniques in the treatment of an Enrollee and his/her partner and/or family simultaneously in the same session.	✓	✓	✓	✓
h. Group Treatment – the use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.	✓	✓	✓	✓
i. Individual Treatment - the use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.	✓	✓	✓	✓
j. Inpatient-Outpatient Bridge Visit - a single-session consultation conducted by an outpatient provider while an Enrollee remains on an Inpatient psychiatric unit. The Inpatient-Outpatient Bridge Visit involves the outpatient Provider meeting with the Enrollee and the inpatient team or designated inpatient treatment team clinician.	✓	✓	✓	✓
k. Assessment for Safe and Appropriate Placement (ASAP) - an assessment, required by MGL 119 Sec. 33B, conducted by a diagnostician with specialized training and experience in the evaluation and treatment of sexually abusive youth or arsonists, to evaluate individuals who are in the care and custody of DCF and who have been adjudicated delinquent for a sexual offense or the commission of arson, or have admitted to such behavior, or are the subject of a documented or substantiated report of such behavior, and who are being discharged from Inpatient Psychiatric Unit or Hospital or Community-Based Acute Treatment for Children/Adolescents or Intensive Community Based Acute Treatment for Children/Adolescents to a family home care setting. Services are provided through a DCF designated ASAP provider.	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
l. Collateral Contact – a communication of at least 15 minutes' duration between a Provider and individuals who are involved in the care or treatment of an Enrollee under 21 years of age, including, but not limited to, school and day care personnel, state agency staff, and human services agency staff.	✓	✓		✓
m. Acupuncture Treatment - the insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, an electric current, heat to the needles or skin, or both, as an aid to persons who are withdrawing from dependence on substances or in recovery from addiction.	✓	✓	✓	✓
n. Opioid Treatment Services — supervised assessment and treatment of an individual, using FDA approved medications (including methadone, buprenorphine/naloxone, and naltrexone) along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. This term encompasses induction of Medication for Opioid Use Disorder (MOUD), withdrawal management, and maintenance treatment. MOUD services may also be provided by outpatient hospital emergency departments in accordance with the MassHealth Acute Hospital Request for Applications (Acute Hospital RFA) as further specified by EOHHS.	✓	✓	✓	✓
o. Ambulatory Withdrawal Management (Level 2WM) - outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Withdrawal Management is provided under the direction of a physician and is designed to stabilize the Member's medical condition under circumstances where neither life nor significant bodily functions are threatened. The severity of the individual's symptoms will determine the setting, as well as the amount of nursing and physician supervision necessary during the course of treatment.	✓	✓	✓	✓
p. Psychological Testing - the use of standardized test instruments to assess an Enrollee's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
q. Special Education Psychological Testing - psychological, emotional or neuropsychological testing which is requested by school personnel responsible for initiating referrals for diagnosis and evaluation of children who qualify for special education programs pursuant to Mass Gen. Law 71B, and which shall be utilized toward the development of an Individualized Educational Plan (IEP). Special Education Psychological Testing shall not be administered more than once a year unless new events have significantly affected the student's academic functioning.	✓	✓		✓
r. Applied Behavioral Analysis for members under 21 years of age (ABA Services) – A MassHealth service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning. See 101 CMR 358.00.	✓	✓		✓
s. Early Intensive Behavioral Intervention (EIBI) - provided to children under three years of age who have a diagnosis of autism spectrum disorder (ASD) and meet clinical eligibility criteria. Such services shall be provided only by DPH-approved, Early Intensive Behavioral Intervention Service Providers.	✓	✓		✓
t. Preventative Behavioral Health Services - short-term interventions in supportive group, individual, or family settings, recommended by a physician or other licensed practitioner, practicing within their scope of licensure, that cultivate coping skills and strategies for symptoms of depression, anxiety, and other social/emotional concerns, which may prevent the development of behavioral health conditions for members who are under 21 years old who have a positive behavioral health screen (or, in the case of an infant, a caregiver with a positive post-partum depression screening), even if the member does not meet criteria for behavioral health diagnosis. Preventive behavioral health services are available in group sessions when delivered in community-based outpatient settings, and in individual, family, and group sessions	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
when provided by a behavioral health clinician practicing in an integrated pediatric primary care setting.				
Intensive Home or Community-Based Services for Youth – mental health and substance use disorder services provided to Enrollees in a community-based setting such as home, school, or community service agency. The services provided are more intensive than services that may be provided through a standard outpatient service. **(See detailed services below)**				
a. Family Support and Training: a service provided to the parent /caregiver of a youth (under the age of 21), in any setting where the youth resides, such as the home and other community settings. Family Support and Training is a service that provides a structured, one-to-one, strength-based relationship between a Family Support and Training Partner and a parent/caregiver. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning. Services may include education, assistance in navigating the child serving systems; fostering empowerment, including linkages to peer/parent support and self-help groups; assistance in identifying formal and community resources, support, coaching, and training for the parent/caregiver.	✓			✓
b. Intensive Care Coordination: a service that provides targeted case management services to individuals under 21 with a Serious Emotional Disturbance including individuals with co-occurring conditions. This service includes assessment, development of an individualized care plan, referral and related activities to implement the care plan and monitoring of the care plan.	✓			✓
c. In-Home Behavioral Services – this service usually includes a combination of behavior management therapy and behavior management monitoring, as follows: **C1. Behavior Management Therapy**: This service includes assessment, development of the behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance. This service addresses challenging behaviors which interfere with the child's successful functioning. The Behavior management therapist develops and monitors specific behavioral objectives and	✓			✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and level of intervention required. Phone contact and consultation may be provided as part of the intervention. **C2. Behavior Management Monitoring**. This service includes implementation of the behavior plan, monitoring the child's behavior, reinforcing implementation of the plan by parents or other caregivers and reporting to the behavior management therapist on implementation of the plan and progress toward behavioral objectives or performance goals. Phone contact and consultation may be provided as part of the intervention.				
d. In-Home Therapy Services. This service is a therapeutic clinical intervention and ongoing training and therapeutic support, as follows: **D1**. The Therapeutic Clinical Intervention is a structured, consistent, therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the child's mental health needs including improving the family's ability to provide effective support for the child to promote healthy functioning of the child within the family. The clinician develops a treatment plan and, using established psychotherapeutic techniques, works with the entire family or a subset of the family, to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions. The Therapeutic Clinical Intervention is provided by a qualified licensed clinician who will often work in a team that includes one or more qualified paraprofessionals. **D2**. Ongoing Therapeutic Training and Support is a service provided by a paraprofessional to support implementation of the licensed clinician's treatment plan to achieve the goals of the treatment plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.				
e. Therapeutic Mentoring Services: This service provides a structured, one-to-one mentoring relationship between a therapeutic mentor and a child or adolescent for the purpose of addressing daily living, social and communication needs. Each child or adolescent will have goals and objectives that are designed to support age-appropriate social functioning or ameliorate deficits in the child or adolescent's age-appropriate social functioning. These goals and objectives are developed by the child or adolescent, as appropriate, and his/her treatment team and are incorporated into the treatment plan. The service includes supporting, coaching and training the child or adolescent in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities. The therapeutic mentor works with the child or adolescent in such settings as their home, school or social or recreational activities.	✓			✓
Crisis Services – Crisis services are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. **(See detailed services below)**				
1. Adult Mobile Crisis Intervention (AMCI) Encounter – each 24-hour period an individual is receiving AMCI Services. Each AMCI Encounter shall include at a minimum: crisis assessment, intervention and stabilization. **a. Assessment** – a face-to-face evaluation of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel; **b. Intervention** – the provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
c. **Stabilization** – short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care. In addition, medication evaluation and specialing services shall be provided if Medically necessary.				
2. **Youth Mobile Crisis Intervention (YMCI)** –a short-term mobile, on-site, face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, seven days a week.	✓	✓		✓
3. **Emergency Department-based Crisis Intervention Mental Health Services (through September 30, 2023):** Behavioral health crisis interventions include the crisis evaluation, stabilization interventions, and disposition coordination activities for members presenting to the ED in a behavioral health crisis. Elements of crisis evaluations include: a. **Crisis Evaluation**: Behavioral Health crisis assessment by a qualified behavioral health professional to individuals within 60 minutes of time of the member's readiness to receive such an assessment. Qualified behavioral health professionals include: qualified behavioral health professional, a psychiatrist, and other master's and bachelor's-level clinicians and staff sufficient to meet the needs of members served which may include certified peer specialists and recovery coaches. b. **Crisis Stabilization Interventions**: Observation, treatment, and support to individuals experiencing a behavioral health crisis. c. **Discharge Planning and Care Coordination**: A disposition plan that includes discharge planning to identify and secure an appropriate level of care and goals for that level of care	✓	✓	✓	✓
4. **Behavioral Health Crisis Evaluation Services in Acute Medical Setting (effective October 1, 2023)** - Crisis evaluations provided in medical and surgical inpatient and emergency department settings include the crisis assessment, crisis interventions, and disposition coordination and reporting and	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
community collaboration activities for members presenting to the ED in a behavioral health crisis. Elements of crisis evaluations include: **a. Comprehensive Behavioral Health Crisis Assessment**: Behavioral Health crisis assessment by a qualified behavioral health professional to individuals within 60 minutes of time of the member's readiness to receive such an assessment. Behavioral Health Crisis Evaluation team must include: qualified behavioral health professional, a complex behavioral health care clinician, and other master's and bachelor's-level clinicians and staff sufficient to meet the needs of members served which may include certified peer specialists and recovery coaches. **b. Crisis Interventions**: Observation, treatment, and support to individuals experiencing a behavioral health crisis **c. Discharge Planning and Care Coordination**: A disposition plan that includes discharge planning to identify and secure an appropriate level of care and goals for that level of care. **d. Reporting and Community Collaboration**: Required reporting of individuals awaiting inpatient psychiatric hospitalization and the establishment of referral relationships with community providers. These services shall be provided in accordance with the Acute Hospital RFA.				
5. Behavioral Health Crisis Management Services in Acute Medical Settings (effective October 1, 2023) – crisis management services provided in medical and surgical inpatient and emergency department settings include ongoing crisis interventions, ongoing determination and coordination of appropriate disposition, and ongoing required reporting and community collaboration activities. Elements of crisis management include: **a. Crisis Interventions**: Observation, treatment, and support to individuals experiencing a behavioral health crisis	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	**MCO MassHealth Family Assistance Enrollees**	**CarePlus**	**Special Kids Special Care**
b. Discharge Planning and Care Coordination: A disposition plan that includes discharge planning to identify and secure an appropriate level of care and goals for that level of care. **c.** Ongoing required reporting and community collaboration These services shall be provided in accordance with the Acute Hospital RFA.				
Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type.				
1. Electro-Convulsive Therapy (ECT) - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.	✓	✓	✓	✓
2. Repetitive Transcranial Magnetic Stimulation (rTMS) - a noninvasive form of neurostimulation in which rapidly changing magnetic fields are applied to the surface of the scalp through a copper wire coil connected to a magnetic stimulator. The therapeutic service is used to treat depression that has not responded to standard treatment such as medications and psychotherapy.	✓	✓	✓	✓
3. Specialing - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.	✓	✓	✓	✓

APPENDIX C
Exhibit 4: MassHealth Excluded Services – All Coverage Types

Except as otherwise noted or determined Medically Necessary by EOHHS, the following services are not covered under MassHealth and as such are not covered by the Contractor.

1. Cosmetic surgery, except as determined by the Contractor to be necessary for:
   a. correction or repair of damage following an injury or illness;
   b. mammoplasty following a mastectomy; or
   c. any other medical necessity as determined by the Contractor.

   All such services determined by the Contractor to be Medically Necessary shall constitute an MCO Covered Service under the Contract.

2. Treatment for infertility, including in-vitro fertilization and gamete intra-fallopian tube (GIFT) procedures.

3. Experimental treatment.

4. Personal comfort items including air conditioners, radios, telephones, and televisions (effective upon promulgation by EOHHS of regulations at 130 CMR regarding non-coverage of air conditioners).

5. Services not otherwise covered by MassHealth, except as determined by the Contractor to be Medically Necessary for MassHealth Standard or MassHealth CommonHealth Enrollees under age 21. In accordance with EPSDT requirements, such services constitute an MCO Covered Service under the Contract.

6. A service or supply which is not provided by or at the direction of a Network Provider, except for:
   a. Emergency Services as defined in **Section 1** of this Contract;
   b. Family Planning Services; and

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

APPENDIX D
PAYMENT

EXHIBIT 1
BASE CAPITATION RATES AND ADD-ONS
Rate Year 2023

Listed below are the Per Member Per Month (PMPM) Base Capitation Rates for Rate Year 2023 (April 1, 2023, through December 31, 2023) (also referred to as RY23), subject to state appropriation and all necessary federal approvals.

Base Capitation Rates do not include EOHHS adjustments described in **Section 4.3** of the Contract.

In addition to the Base Capitation Rates tables below, additional tables include the add-on for the Contract Year, for ABA Services as described in **Section 4.5.E**, for High Cost Drugs as described in **Section 4.5.F** and for SUD Risk Sharing Services as described in **Section 4.5.G**. The add-on for High Cost Drugs, ABA Services and SUD Risk Sharing Services are the same for all Regions and will be added to the Risk Adjusted Capitation Rates as defined in **Section 4.2.E**.

MCO Base Capitation Rates / RC I Adult			
Effective April 1, 2023 – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$590.51	$48.36	$638.87
Greater Boston	$616.25	$54.04	$670.29
Southern	$633.81	$54.62	$688.43
Central	$587.58	$49.24	$636.82
Western	$543.03	$51.69	$594.72

MCO Base Capitation Rates / RC I Child			
Effective April 1, 2023 – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$240.59	$36.52	$277.11
Greater Boston	$264.06	$44.44	$308.50
Southern	$253.88	$43.64	$297.52
Central	$257.05	$36.86	$293.91
Western	$266.49	$44.06	$310.55

MCO Base Capitation Rates / RC II Adult			
Effective April 1, 2023 – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$2,062.98	$111.19	$2,174.17
Greater Boston	$2,223.77	$128.44	$2,352.21
Southern	$2,160.22	$122.00	$2,282.22
Central	$2,026.90	$111.03	$2,137.93
Western	$1,752.96	$106.63	$1,859.59

MCO Base Capitation Rates / RC II Child			
Effective April 1, 2023 – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,269.39	$100.88	$1,370.27
Greater Boston	$1,286.78	$118.61	$1,405.39
Southern	$1,195.68	$107.54	$1,303.22
Central	$1,071.02	$91.85	$1,162.87
Western	$910.81	$87.25	$998.06

MCO Base Capitation Rates / RC IX			
Effective April 1, 2023 – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$645.11	$50.00	$695.11
Greater Boston	$644.41	$54.90	$699.31
Southern	$725.82	$58.41	$784.23
Central	$683.22	$52.09	$735.31
Western	$627.79	$54.60	$682.39

MCO Base Capitation Rates / RC X			
Effective April 1, 2023 – December 31, 2023 (RY23)			
REGION	CORE MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$2,130.61	$111.39	$2,242.00
Greater Boston	$2,283.17	$126.99	$2,410.16
Southern	$1,998.47	$115.28	$2,113.75
Central	$1,851.38	$101.80	$1,953.18
Western	$1,600.05	$97.48	$1,697.53

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

High Cost Drug Add-On to Risk Adjusted Capitation Rates PMPM					
REGION	**Northern**	**Greater Boston**	**Southern**	**Central**	**Western**
RC I Adult	**$5.93**	**$3.28**	**$1.69**	**$5.45**	**$0.41**
RC I Child	**$6.02**	**$6.05**	**$3.86**	**$2.71**	**$2.69**
RC II Adult	**$18.14**	**$11.32**	**$16.74**	**$62.86**	**$22.08**
RC II Child	**$64.51**	**$133.30**	**$21.26**	**$116.34**	**$29.65**
RC IX	**$6.52**	**$9.15**	**$5.31**	**$15.12**	**$4.84**
RC X	**$2.95**	**$4.12**	**$4.61**	**$1.51**	**$1.52**

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

ABA Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	**$5.22**
RC-II Child	**$173.66**

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

SUD Risk Sharing Services Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Adult	**$11.50**
RC-I Child	**$0.37**
RC-II Adult	**$26.74**
RC-II Child	**$0.05**
RC-IX	**$20.92**
RC-X	**$238.88**

EXHIBIT 2
ADJUSTMENTS OR ADDITIONS TO PAYMENTS
Rate Year 2023

The table shows the admission-level stop-loss attachment point for the Contract Year as described in **Section 4.3.B**.

Admission Level Stop-Loss Attachment Point
$150,000

EXHIBIT 3
RISK SHARING ARRANGEMENTS
Rate Year 2023

Market-Wide Risk Sharing Arrangement (Market Corridor) (Section 4.5.C)

If the Market Corridor expenditures, as determined by EOHHS in accordance with **Section 4.5.C.3**, are greater than or less than the Market Corridor revenue, as determined by EOHHS in accordance with **Section 4.5.C.2**, the Contractor and EOHHS shall share the resulting loss or gain as follows:

1. **Gain on the Market Corridor**

Gain	MassHealth Share	Market Share
Absolute value of the Gain less than or equal to 0.75% of the Market Corridor Revenue	0%	100%
Absolute value of the Gain greater than 0.75% of the Market Corridor Revenue	95%	5%

2. **Loss on the Market Corridor**

Loss	MassHealth Share	Market Share
Absolute value of the Loss less than or equal to 0.75% of the Market Revenue	0%	100%
Absolute value of the Loss greater than 0.75% of the Market Revenue	95%	5%

Contract-Wide Risk Sharing Arrangement ("Plan Corridor") (Section 4.5.D)

If the Contractor's Plan Corridor expenditures, as determined by EOHHS in accordance with **Section 4.5.D.3**, is greater than or less than the Contractor's Plan Corridor revenue as determined by EOHHS in accordance with **Section 4.5.D.2**, the Contractor and EOHHS shall share the resulting loss or gain as follows:

1. **Gain on the Plan Corridor**

Gain	MassHealth Share	Contractor Share
Absolute value of the Gain less than or equal to 5% of Plan Corridor Revenue	0%	100%
Absolute value of the Gain greater than 5% of the Plan Corridor Revenue	95%	5%

2. **Loss on the Plan Corridor**

Loss	MassHealth Share	Contractor Share
Absolute value of the Loss less than or equal to 5% of Plan Corridor Revenue	0%	100%
Absolute value of the Loss greater than 5% of the Plan Corridor Revenue	95%	5%

ABA Services Risk Sharing Arrangement (Section 4.5.E)

If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.E.2**, is greater than or less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.E.3**, then the Contractor shall be considered to have experienced a gain or a loss with respect to ABA Services for the Contract Year. EOHHS and the Contractor shall share such gain or loss as follows:

1. **Gain on the ABA Add-On to the Risk Adjusted Capitation Rate**

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

2. **Loss on the ABA Add-On to the Risk Adjusted Capitation Rate**

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

High Cost Drug Add-On Risk Sharing Arrangement (Section 4.5.F)

1. **Gain on the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment**

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

Gain	MassHealth Share	Contractor Share
Gain up to $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	99%	1%
Gain of more than $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	100%	0%

2. **Loss on the High Cost Drug Add-On to the Risk Adjusted Capitation Rate Payment**

Loss	MassHealth Share	Contractor Share
Loss up to $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	99%	1%
Loss of more than $100,000 for the High Cost Drug Add-On to the Risk Adjusted Capitation Rate payment	100%	0%

SUD Services Risk Sharing Arrangement (Section 4.5.G)

If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.G.2**, is greater than or less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.G.3**, then the Contractor shall be considered to have experienced a gain or a loss with respect to SUD Risk Sharing Services for the Contract Year. EOHHS and the Contractor shall share such gain or loss as follows:

1. **Gain on the SUD Risk Sharing Services Add-On to the Risk Adjusted Capitation Rate**

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

2. **Loss on the SUD Risk Sharing Services Add-On to the Risk Adjusted Capitation Rate**

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

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90791*	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation	$ 208.27
MH and SA OP Services	90791*	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation	$ 167.15
MH and SA OP Services	90791*	AH - Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 143.48
MH and SA OP Services	90791*	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation	$ 144.66
MH and SA OP Services	90791*	HO - Master's Level	Psychiatric Diagnostic Evaluation	$ 130.48
MH and SA OP Services	90791*	U3 - Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Evaluation	$ 81.83
MH and SA OP Services	90791*	U4 - Intern (Master's)	Psychiatric Diagnostic Evaluation	$ 72.20
MH and SA OP Services	90791	HA - CANS; UG-Doctoral Level (Child Psychiatrist)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 223.27
MH and SA OP Services	90791	HA - CANS; U6-Doctoral Level (MD / DO)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 182.15
MH and SA OP Services	90791	HA - CANS; AH-Doctoral Level (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 158.48
MH and SA OP Services	90791	HA - CANS; SA, UF -Nurse Practitioner/Board Certified RNCS and APRN-BC	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 159.66
MH and SA OP Services	90791	HA - CANS; HO-Master's Level	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 145.48
MH and SA OP Services	90791	HA - CANS; U3-Intern (PhD, PsyD, EdD)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 96.83
MH and SA OP Services	90791	HA - CANS; U4-Intern (Master's)	CANS - Psychiatric Diagnostic Evaluation, Members under 21	$ 87.20
MH and SA OP Services	90792	UG - Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 131.80
MH and SA OP Services	90792	U6 - Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 114.31
MH and SA OP Services	90792	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychiatric Diagnostic Evaluation with Medical Services	$ 104.57
MH and SA OP Services	90832	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 69.60
MH and SA OP Services	90832	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16
MH and SA OP Services	90832	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 20-30 minutes	$ 59.16

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90832	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 52.20
MH and SA OP Services	90832	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 20-30 minutes	$ 35.49
MH and SA OP Services	90832	U4 - Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 31.32
MH and SA OP Services	90833	U6 - Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 63.83
MH and SA OP Services	90833	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 54.25
MH and SA OP Services	90834	UG - Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 45 minutes	$ 115.70
MH and SA OP Services	90834	U6 - Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 45 minutes	$ 101.66
MH and SA OP Services	90834	AH - Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 45 minutes	$ 95.89
MH and SA OP Services	90834	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Individual Psychotherapy, approximately 45 minutes	$ 95.46
MH and SA OP Services	90834	U3 - Intern (PhD, PsyD, EdD) / or MAT	Individual Psychotherapy, approximately 45 minutes	$ 47.98
MH and SA OP Services	90834	U4 - Intern (Master's)	Individual Psychotherapy, approximately 45 minutes	$ 47.26
MH and SA OP Services	90836	U6 - Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90836	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 82.90
MH and SA OP Services	90837	UG - Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 135.04
MH and SA OP Services	90837	AH - Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 127.53

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90837	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Psychotherapy, 60 minutes	$ 125.69
MH and SA OP Services	90837	U3 - Intern (PhD, PsyD, EdD) / or MAT	Psychotherapy, 60 minutes	$ 68.87
MH and SA OP Services	90837	U4 - Intern (Master's)	Psychotherapy, 60 minutes	$ 60.77
MH and SA OP Services	90838	U6 - Doctoral Level (MD / DO)	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 106.08
MH and SA OP Services	90838	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 91.42
MH and SA OP Services	90846	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (without patient present)	$ 141.42
MH and SA OP Services	90846	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (without patient present)	$ 107.62
MH and SA OP Services	90846	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (without patient present)	$ 100.47
MH and SA OP Services	90846	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (without patient present)	$ 97.55
MH and SA OP Services	90846	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (without patient present)	$ 101.43
MH and SA OP Services	90846	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (without patient present)	$ 50.23
MH and SA OP Services	90846	U4 - Intern (Master's)	Family Psychotherapy (without patient present)	$ 48.77
MH and SA OP Services	90847	UG - Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 141.42
MH and SA OP Services	90847	U6 - Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 107.62
MH and SA OP Services	90847	AH - Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90847	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 101.43
MH and SA OP Services	90847	U3 - Intern (PhD, PsyD, EdD) / or MAT	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 50.23
MH and SA OP Services	90847	U4 - Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 48.77
MH and SA OP Services	90849	UG - Doctoral Level (Child Psychiatrist)	Multi-family group psychotherapy	$ 46.29
MH and SA OP Services	90849	U6 - Doctoral Level (MD / DO)	Multi-family group psychotherapy	$ 38.84
MH and SA OP Services	90849	AH - Doctoral Level (PhD, PsyD, EdD)	Multi-family group psychotherapy	$ 35.86
MH and SA OP Services	90849	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Multi-family group psychotherapy	$ 33.00
MH and SA OP Services	90849	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Multi-family group psychotherapy	$ 27.69
MH and SA OP Services	90849	U3 - Intern (PhD, PsyD, EdD) / or MAT	Multi-family group psychotherapy	$ 17.96
MH and SA OP Services	90849	U4 - Intern (Master's)	Multi-family group psychotherapy	$ 16.50
MH and SA OP Services	90853	UG - Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 46.29
MH and SA OP Services	90853	U6 - Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 38.84
MH and SA OP Services	90853	AH - Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 35.86
MH and SA OP Services	90853	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Group psychotherapy (other than of a multiple-family group)	$ 33.12
MH and SA OP Services	90853	U3 - Intern (PhD, PsyD, EdD) / or MAT	Group psychotherapy (other than of a multiple-family group)	$ 17.96
MH and SA OP Services	90853	U4 - Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 16.50

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90882	UG - Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 51.11
MH and SA OP Services	90882	U6 - Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 44.33
MH and SA OP Services	90882	AH - Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.97
MH and SA OP Services	90882	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 38.36
MH and SA OP Services	90882	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 23.63
MH and SA OP Services	90882	U3 - Intern (PhD, PsyD, EdD) / or MAT	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 12.00
MH and SA OP Services	90882	U4 - Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 11.81
MH and SA OP Services	90887	UG - Doctoral Level (Child Psychiatrist)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	U6 - Doctoral Level (MD / DO)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 79.19
MH and SA OP Services	90887	AH - Doctoral Level (PhD, PsyD, EdD)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 67.32
MH and SA OP Services	90887	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 59.40
MH and SA OP Services	90887	U3 - Intern (PhD, PsyD, EdD) / or MAT	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 40.39

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90887	U4 - Intern (Master's)	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	$ 35.64
MH and SA OP Services	96372	U6 - Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 31.25
MH and SA OP Services	96372	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Therapeutic, Prophylactic or Diagnostic Injection; subcutaneous or intramuscular	$ 23.22
MH and SA OP Services	97810	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-to-one contact	$ 19.84
MH and SA OP Services	97811	*N/A*	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-to-one contact with re-insertion of needle(s).	$ 19.84
MH and SA OP Services	99202	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 15-29 minutes	$ 75.25
MH and SA OP Services	99202	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 15-29 minutes	$ 67.91
MH and SA OP Services	99202	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 15-29 minutes	$ 60.78
MH and SA OP Services	99203	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 30-44 minutes	$ 108.55
MH and SA OP Services	99203	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 30-44 minutes	$ 103.65
MH and SA OP Services	99203	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 30-44 minutes	$ 88.11
MH and SA OP Services	99204	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 45-59 minutes	$ 164.00
MH and SA OP Services	99204	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 45-59 minutes	$ 153.89
MH and SA OP Services	99204	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 45-59 minutes	$ 133.25
MH and SA OP Services	99205	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.69
MH and SA OP Services	99205	U6 - Doctoral Level (MD / DO)	Evaluation and Management for New Patient, 60-74 minutes	$ 203.31
MH and SA OP Services	99205	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for New Patient, 60-74 minutes	$ 172.81
MH and SA OP Services	99211	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 5 minutes	$ 22.06
MH and SA OP Services	99211	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 5 minutes	$ 22.06
MH and SA OP Services	99211	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 5 minutes	$ 18.75
MH and SA OP Services	99212	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 52.73
MH and SA OP Services	99212	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 10-19 minutes	$ 52.73

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99212	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 10-19 minutes	$ 44.82
MH and SA OP Services	99213	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 84.11
MH and SA OP Services	99213	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 20-29 minutes	$ 84.11
MH and SA OP Services	99213	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 20-29 minutes	$ 71.49
MH and SA OP Services	99214	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 143.98
MH and SA OP Services	99214	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 30-39 minutes	$ 118.51
MH and SA OP Services	99214	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 30-39 minutes	$ 100.73
MH and SA OP Services	99215	UG - Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 166.57
MH and SA OP Services	99215	U6 - Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient, 40-54 minutes	$ 166.57
MH and SA OP Services	99215	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Evaluation and Management for an Established Patient, 40-54 minutes	$ 141.58
MH and SA OP Services	99231	UG - Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 78.07
MH and SA OP Services	99231	U6 - Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 59.27
MH and SA OP Services	99231	AH - Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 56.89
MH and SA OP Services	99231	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 15 minutes	$ 47.47
MH and SA OP Services	99232	UG - Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 117.11
MH and SA OP Services	99232	U6 - Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 88.19
MH and SA OP Services	99232	AH - Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 84.66
MH and SA OP Services	99232	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 25 minutes	$ 70.63
MH and SA OP Services	99233	UG - Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 156.16
MH and SA OP Services	99233	U6 - Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 117.59
MH and SA OP Services	99233	AH - Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 112.88
MH and SA OP Services	99233	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Subsequent Hospital Care for Eval and Management, 35 minutes	$ 94.18

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99251	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 104.74
MH and SA OP Services	99251	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 79.50
MH and SA OP Services	99251	AH - Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 76.32
MH and SA OP Services	99251	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 63.67
MH and SA OP Services	99252	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 157.11
MH and SA OP Services	99252	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 118.32
MH and SA OP Services	99252	AH - Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 113.58
MH and SA OP Services	99252	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 40 minutes	$ 94.77
MH and SA OP Services	99253	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 209.47
MH and SA OP Services	99253	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 157.74
MH and SA OP Services	99253	AH - Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 151.44
MH and SA OP Services	99253	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 55 minutes	$ 126.35
MH and SA OP Services	99254	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 280.95
MH and SA OP Services	99254	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 210.98
MH and SA OP Services	99254	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation, 80 minutes	$ 169.00
MH and SA OP Services	99255	UG - Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 370.12
MH and SA OP Services	99255	U6 - Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 277.57
MH and SA OP Services	99255	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Initial Inpatient Consultation - Comprehensive, 110 minutes	$ 222.33
MH and SA OP Services	99281	U6 - Doctoral Level (MD / DO)	o	$ 20.14
MH and SA OP Services	99282	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 35.37

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99282	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 33.68
MH and SA OP Services	99282	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.	$ 32.70
MH and SA OP Services	99283	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 53.52
MH and SA OP Services	99283	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 50.97
MH and SA OP Services	99283	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	$ 49.49

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99284	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 100.58
MH and SA OP Services	99284	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 95.80
MH and SA OP Services	99284	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.	$ 93.01
MH and SA OP Services	99285	UG - Doctoral Level (Child Psychiatrist)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 148.78

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99285	U6 - Doctoral Level (MD / DO)	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 141.69
MH and SA OP Services	99285	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	$ 136.30
MH and SA OP Services	99402	AH - Doctoral Level (PhD, PsyD, EdD)	Preventative Medicine Counseling , 30 minutes (Psychological Testing)	$ 40.98
MH and SA OP Services	99402	U3 - Intern (PhD, PsyD, EdD) / or MAT	Preventative Medicine Counseling, 30 minutes (Psychological Testing)	$ 20.50
MH and SA OP Services	99404	U6 - Doctoral Level (MD / DO)	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 194.82
MH and SA OP Services	99404	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Preventative Medicine Counseling, 60 minutes (Counseling and/or Risk Factor Reduction Intervention)	$ 168.60
MH and SA OP Services	99417	U6 - Doctoral Level (MD / DO)	Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
MH and SA OP Services	99417	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Prolonged office or other outpatient evaluation and management service, requiring total time with or without direct patient contact beyond usual service, on the date of the primary service (e.g., 99205 or 99215), each 15 minutes	$ 26.08
Diversionary Services	H0015	TF	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)	101 CMR 306

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H0015	N/A	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)	Effective July 1, 2023, $78.75
Diversionary Services	H0037	N/A	Community Psychiatric Supportive Treatment Program, per diem (Community Based Acute Treatment - CBAT)	Effective July 1, 2023, $719.54
Diversionary Services	H0037	U2-Autism Diagnosis	Community Psychiatric Supportive Treatment Program, per diem (CBAT Autism Speciality)	$ 1,093.70
Diversionary Services	H2012	+	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment)	Effective 10/1/23 until further directed by EOHHS: $28.77 When directed by EOHHS: 101 CMR 307
Diversionary Services	H2012	U1	Behavioral Health Day Treatment, per hour (Psychiatric Day Treatment, preadmission evaluation visit)	Effective 10/1/23 until further directed by EOHHS: $80.13 When directed by EOHHS: 101 CMR 307
Diversionary Services	H2015	HF - Substance Abuse Program	Recovery Support Navigator, per 15-minute units, including when provided in an Emergency Department or on a medicial or surgical inpatient setting	101 CMR 444
Diversionary Services	H2016	HM - Less than bachelor degree level	Comprehensive community support program, per diem (Enrolled Client Day) (recovery support service by a recovery advocate trained in Recovery Coaching)	101 CMR 346
Diversionary Services	H2015	+	Comprehensive community support services, per 15 minutes (Community Support Program)	101 CMR 362.00
Diversionary Services	H2016	HH - Integrated Mental Health/Substance Abuse Program	Comprehensive community support program, per diem for members with justice involvement and behavioral health needs	101 CMR 362
Diversionary Services	H2016	HK - Specialized mental health programs for high-risk populations	Comprehensive community support program, per diem, for members who are 1) experiencing Homelessness and are frequent users of acute health MassHealth services, or 2) are experiencing chronic homelessness	101 CMR 362

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H2016	HE - Mental Health Program	Comprehensive community support program, per diem, for members who are At Risk of Homelessness and facing Eviction as a result of behavior related to a disability	101 CMR 362
Diversionary Services	H2020	+	Therapeutic behavioral services, per diem (Dialectical Behavior Therapy)	$ 26.50
Diversionary Services	H2022	HE-Mental Health Program	Intensive Hospital Diversion Services for Children, per diem	$ 175.19
Diversionary Services	S9484	+	Crisis intervention mental health services, per hour (Urgent Outpatient Services)	$ 147.57
MH and SA OP Services	H0014	+	Alcohol and/or drug services; ambulatory detoxification (Adult or Adolescent)	$ 227.65
Crisis Intervention Services	S9485	ET - Emergency Services	Crisis intervention mental health services, per diem. (Adult Community Crisis Stabilization per day rate)	101 CMR 305
Crisis Intervention Services	S9485	ET - Emergency Services; HA - Child/Adolescent Program	Crisis intervention mental health services, per diem. (Youth Community Crisis Stabilization Per day rate)	101 CMR 305
Crisis Intervention Services	S9485	HB - Adult Program, non-geriatric	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at hospital emergency department. Inclusive of initial evaluation and all follow-up intervention. Use Place of Service code 23.)	$ 695.29
Crisis Intervention Services	S9485	HE - Mental Health Program	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	HA-Child/Adolescent Program; HE-Mental Health Program	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at CBHC site. Inclusive of initial evaluation and first day crisis interventions.)	101 CMR 305
Crisis Intervention Services	S9485	U1-MCI - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health services, per diem. (Adult Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions. Use Place of Service 15.)	101 CMR 305
Crisis Intervention Services	S9485	HA - Child/Adolescent Program; U1 - MCI - Mobile Non-Emergency Department / or MAT	Crisis intervention mental health services, per diem. (Youth Mobile Crisis Intervention provided at community-based sites of service outside of the CBHC site. Inclusive of initial evaluation and first day crisis interventions Use Place of Service code 15.)	101 CMR 305
Other Outpatient	90870	+	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	96112	AH - Doctoral Level (PhD, PsyD, EdD)	Developmental Testing administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour (Learning Disorders)	$ 180.72
Other Outpatient	96113	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Developmental/Behavioral Screening and Testing)	$ 90.36
Other Outpatient	96116	AH - Doctoral Level (PhD, PsyD, EdD)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician o rother qualified health professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	$ 120.46
Other Outpatient	96121	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 120.46
Other Outpatient	96130	AH - Doctoral Level (PhD, PsyD, EdD)	Psychological testing evaluation services by physician or other qualified health care professional, including integrating of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Effective July 1, 2023, $107.49
Other Outpatient	96131	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	$ 91.39
Other Outpatient	96132	AH - Doctoral Level (PhD, PsyD, EdD)	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	Effective July 1, 2023, $121.84
Other Outpatient	96133	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional hour (List separately in addition to code for primary procedure)	Effective July 1, 2023, $100.53
Other Outpatient	96136	AH - Doctoral Level (PhD, PsyD, EdD)	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes (Test administration and scoring by professional)	Effective July 1, 2023, $50.27
Other Outpatient	96137	AH - Doctoral Level (PhD, PsyD, EdD)	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by professional)	$ 45.70
Other Outpatient	96138	Technician	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	Effective July 1, 2023, $37.75
Other Outpatient	96139	Technician	Each additional 30 minutes (List separately in addition to code for primary procedure) (Test administration and scoring by technician)	Effective July 1, 2023, $37.75

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

Appendix O: Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule (effective July 1, 2023)

Behavioral Health Outpatient and Certain Other Services Minimum Fee Schedule				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	H0032	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health service plan development by a nonphysician (Bridge consultation inpatient/outpatient)	$ 166.67
Other Outpatient	H0046	UG - Doctoral Level (Child Psychiatrist)	Mental health services, not otherwise specified (Collateral Contact)	$ 46.46
Other Outpatient	H0046	U6 - Doctoral Level (MD/DO)	Mental health services, not otherwise specified (Collateral Contact)	$ 40.30
Other Outpatient	H0046	AH - Doctoral Level (PhD, PsyD, EdD)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.79
Other Outpatient	H0046	SA - Nurse Practitioner/Board Certified RNCS and APRN-BC	Mental health services, not otherwise specified (Collateral Contact)	$ 34.87
Other Outpatient	H0046	HO - Master's Level (Independently Licensed Clinicians, Licensed Alcohol and Drug Counselor 1, and Supervised Master's Level Clinicians)	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U7 - Certified Addiction Counselor / Certified Alcohol & Drug Abuse Counselor	Mental health services, not otherwise specified (Collateral Contact)	$ 21.48
Other Outpatient	H0046	U3 - Intern (PhD, PsyD, EdD) / or MAT	Mental health services, not otherwise specified (Collateral Contact)	$ 10.91
Other Outpatient	H0046	U4 - Intern (Master's)	Mental health services, not otherwise specified (Collateral Contact)	$ 10.74
Other Outpatient	H0046	HE-Mental Health Program	Mental health services, not otherwise specified (Certified Peer Specialist)	101 CMR 305
Other Outpatient	H2028		Sexual offender treatment service, per 15 minutes (ASAP - Assessment for Safe and Appropriate Placement)	$ 22.79
MH and SA OP Services	H0001~~-U1~~	U1 - ESP - Mobile Non-Emergency Department / or MAT	Alcohol and/or drug assessment (buprenorphine and naltrexone medication evaluation by physician and/or midlevel practitioner)	$ 146.93
MH and SA OP Services	H0004		Behavioral health counseling and therapy, per 15 minutes (individual counseling)	101 CMR 346
MH and SA OP Services	H0005		Alcohol and/or drug services; group counseling by a clinician (per 45 minutes, group counseling, one unit maximum per day)	101 CMR 346
MH and SA OP Services	H0005	HG	Alcohol and/or drug services group counseling by a clinician (per 90-minute unit) (one unit maximum per day)	101 CMR 346
MH and SA OP Services	T1006		Alcohol and/or substance abuse services; family/couple counseling (per 30 minutes, one unit maximum per day)	101 CMR 346
MH and SA OP Services	T1006	HF	Alcohol and/or substance abuse services; family/couple counseling (per 60 minutes, one unit maximum per day)	101 CMR 346

* See Section 2.8.C.3.e.1 for adjustment to unit cost if using CANS Tool.

APPENDIX P

Requirements for the Material Subcontracts Between Managed Care Organizations (MCOs) and Community Partners (CPs)

The Contractor shall maintain material subcontracts (also known as MCO-CP Agreements) with at least one (1) Behavioral Health Community Partner (BH CP) and at least one (1) Long Term Services and Supports Community Partner (LTSS CP) within each of the Contractor's Service Area(s), as specified in **Section 2.6.E** of the Contract and in this **Appendix P**. The Contractor's CP material subcontracts, referred to in this Appendix as "subcontracts," shall be provided to EOHHS upon request and may be reviewed by EOHHS. All requirements set forth herein are applicable to subcontracts with both BH CPs and LTSS CPs unless otherwise specified.

All terms or their abbreviations, when capitalized in this Appendix, are defined as set forth in the Contract or otherwise defined by EOHHS. The Contractor and the CP with which the Contractor enters into a subcontract are referred to collectively herein as the "Parties."

The Parties' subcontracts must comply with applicable laws and regulations, including but not limited to applicable privacy laws and regulations, and with the Contractor's Contract with EOHHS.

The Parties' subcontracts must, at a minimum, contain the information included in this document.

Section 1.1 PAYMENT

A. The Parties' subcontract shall obligate the Contractor to pay the CP as described in **Section 2.6.E.9**.

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

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

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

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

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

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

c. Add-on payment for Enrollees in the Oak Bluffs and Nantucket Service Areas for Calendar Year 2023 for BH CPs only: $100 PMPM, or as further specified by EOHHS.

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

3. The Contractor shall reconcile monthly panel-based payments to CPs as further specified by EOHHS.

Section 1.2 CP Supports

In addition to the enhanced care coordination requirements described in **Section 2.6.C** of the Contract delegated to the CP by the Contractor, the Parties' subcontract shall require the following:

A. Outreach and Engagement

The Parties' subcontract shall require that the CP develop, implement, maintain, and adhere to a protocol for outreach and engagement of CP Enrollees. Such protocol shall include the requirements in **Section 2.6.C.3** of the Contract, as well as the following requirements:

1. Require the CP to attempt at least one face-to-face visit with each CP Enrollee within the first 3 calendar months of the Enrollee's enrollment in the CP.

2. For each CP Enrollee who agrees to participate in the CP program, require the CP to:

a. Attest that the CP has performed the outreach and activities described in **Section 2.6.C.3** of the Contract and **Section 1.2** of this **Appendix P** and obtained verbal or written agreement from the CP Enrollee to receive or continue receiving CP supports;

b. Maintain a copy of the attestation and the CP Enrollee's written agreement, or a record of the CP Enrollee's verbal agreement, if applicable, in the CP Enrollee's record; and

c. Explain the Protected Information (PI) the CP intends to obtain, use, and share for purposes of providing CP supports;

d. To the extent deemed necessary by the CP, obtain the CP Enrollee's written authorization to the uses and disclosures of their Protected Information (PI) as necessary for providing CP supports.

3. Require the CP to notify the Contractor if the CP Enrollee declines to participate in the CP program or requests enrollment in a different CP.

4. For BH CPs only, for BH CP Enrollees the BH CP believes are experiencing homelessness or are at risk of homelessness, require the CP use the Homeless Management Information System (HMIS) or other means to:

    a. Confirm whether the Enrollee is currently experiencing or has a history of experiencing homelessness or unstable housing;

    b. Identify which homeless provider agencies and agency staff have worked with the Enrollee, if any. If the Enrollee is not connected with a homeless provider agency, the CP shall immediately work to connect the Enrollee with a homeless provider agency; and

    c. Once the homeless provider agencies and agency staff are identified or connected to the Enrollee, conduct outreach to the homeless provider agencies to gather additional information and invite the homeless provider to participate in the Care Team and care planning for the Enrollee.

B. Comprehensive Assessment

The Parties' subcontract shall require that, for each Enrollee who agrees to participate in the program, the CP shall complete a Comprehensive Assessment, as described in **Section 2.5.B.4** of the Contract. The CP shall utilize a Comprehensive Assessment tool of their choosing that meets the requirements as set forth in **Section 2.5.B.4**. In addition to the requirements in **Section 2.5.B.4** of the Contract, the Parties' subcontract shall require the following:

1. The CP shall perform Comprehensive Assessments face-to-face unless otherwise specified by EOHHS, and shall take place in a location that meets the Enrollee's needs, including home-based assessments as appropriate.

2. A registered nurse (RN) employed by the CP must review and agree to the Enrollee's medical history, medical needs, medications, and functional status, including needs for assistance with any Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

3. A Clinical Care Manager employed by the CP shall provide final review and approval of the entire Comprehensive Assessment. If the Clinical Care Manager is an RN, review and approval of the Comprehensive Assessment may be completed by one staff member provided all requirements of this Section are met.

C. Health-Related Social Needs Screening and Connection to Community and Social Supports

The Parties' subcontract shall require that, for each Enrollee who agrees to participate in the program, the CP shall complete a health-related social needs (HRSN) Screening, as described in **Section 2.5.B.3** of the Contract, and shall utilize such tool in connecting

Enrollees to community and social supports. In addition to the requirements in **Section 2.5.B.3** of the Contract, the Parties' subcontract shall require the CP to do the following:

1. Conduct a health-related social needs (HRSN) screening upon enrollment to the CP for those Enrollees who have not had an HRSN screening within the last twelve (12) calendar months that includes all domains and considerations described in **Section 2.5.B.3** of the Contract, and annually thereafter. The HRSN screening may occur as a unique screening, or as part of the Comprehensive Assessment.
2. Utilize the results of any such HRSN screenings when creating a Care Plan and coordinating care.
3. Provide its Heath-Related Social Needs Screening tool to the Contractor and to EOHHS upon request for review and shall make any changes to such tool as directed by EOHHS. EOHHS may require the Contractor to use a specific tool in place of the Contractor's proposed tool.
4. Identify supports to address the Enrollee's identified HRSN(s), including using tools such as the Community Resource Database (CRD) which is provided to the CP by the Contractor, as appropriate;
5. Provide the Enrollee with information about available HRSN-related supports, how to contact such supports, and the accessibility of such supports;
6. Ensure such Enrollees are referred to HRSN-related supports provided by the Contractor, or a Social Services Organization, as applicable. For Enrollees who are referred to a Social Services Organization, the CP shall confirm the Social Services Organization has the capacity to provide services to the Enrollee and, if not, arrange a referral to another Social Services Organization;
7. Document relevant ICD-10 codes (such as "Z codes" included in categories Z55-65 and Z75 and as further specified by EOHHS);
8. Submit to the Contractor aggregate reports of the identified HRSNs of its enrollees, as well as how those enrollees were referred to appropriate resources to address those identified HRSNs, in a form, format, and frequency specified by EOHHS;
9. Coordinate supports to address HRSNs, including:

    a. Assisting the Enrollee in attending the referral appointment, including activities such as coordinating transportation assistance and following up after missed appointments;

    b. Directly introducing the Enrollee to the service provider, if co-located, during a visit;

    c. Utilizing electronic referral (e.g., electronic referral platform, secure e-mail) to connect the Enrollee with the appropriate provider or Social Service Organization, if the Social Service Organization has electronic referral capabilities, including sharing relevant patient information;

d. Following up electronically (e.g., electronic referral platform, secure e-mail) with the provider or Social Service Organization, if the Social Service Organization has electronic follow-up capabilities, as needed, to ensure the Enrollee's needs are met.

10. The CP to shall document results of the HRSN screening and include a list of the community and social services resources the Enrollee needs in the Enrollee's Care Plan, as described in **Section 1.2.D** of this Appendix.

D. Development of Care Plan

The Parties' subcontract shall require that the CP develop a Care Plan as described in **Section 2.5.B.5** of the Contract. The CP shall utilize a Care Plan template approved by the Contractor that meets the requirements of **Section 2.5.B.5** of the Contract. In addition to the requirements in **Section 2.5.B.5**, the Parties' subcontract shall require the following:

1. Care Plans shall be reviewed by a registered nurse (RN) employed by the CP. Care Plans shall receive final review and approval by a Clinical Care Manager employed by the CP.
2. The CP shall document within the Enrollee record that the Care Plan was provided to, agreed to, and signed or otherwise approved by the Enrollee.
3. The CP shall complete Care Plans within five (5) calendar months of Enrollee's enrollment with the CP. A Care Plan shall be considered complete when:

    a. The Care Plan has been signed or otherwise approved by the Enrollee; and

    b. The Care Plan has been shared with the Enrollee's PCP or PCP Designee.

4. The CP shall share the completed Care Plan with the Contractor and other parties who need the Care Plan in connection with their treatment of the Enrollee, provision of coverage or benefits to the Enrollee, or related operational activities involving the Enrollee, including members of the Enrollee's Care Team, CBHC staff, if applicable, and other providers who serve the Enrollee, including state agency or other case managers, in accordance with all data privacy and data security provisions applicable.

E. Care Team

The Parties' subcontract shall require that the CP take the lead on forming and coordinating a Care Team for each Enrollee, as described in **Section 2.6.C.4** of the Contract. In addition, the CP shall ensure:

1. That the Care Team meets at least twice within a 12-month period, and
2. That a representative from the care team attends any multidisciplinary team meetings hosted by the Contractor, clinical staff, hospitals and/or other stakeholders to review high-risk Members, if applicable;

F. Care Coordination

The Parties' subcontract shall require that the Enrollee's CP Care Coordinator provide ongoing care coordination support to the Enrollee in coordination with the Enrollee's PCP and other providers as set forth in **Section 2.6.A and Section 2.6.C** of the Contract. In addition, the Parties' subcontract shall:

1. Require CPs to assist Enrollees in the following activities:

    a. For Enrollees with behavioral health needs, coordinating with the Enrollee's behavioral health providers to develop the Enrollee's Crisis Prevention Plan to prevent avoidable use of emergency departments, hospitalizations and criminal justice involvement and to provide follow-up if these events occur. The Crisis Prevention Plan shall be documented in the Enrollee's record and shared with the Enrollee's Care Team and other providers.

    b. For Enrollees with LTSS needs, assisting with prior authorization for MassHealth State Plan LTSS as applicable. If a service request is significantly modified or denied by MassHealth, the CP shall work with the Enrollee to ensure the Care Plan is adequate to meet the CP Enrollee's needs by working with the CP Enrollee to identify other appropriate supports to meet an unmet need.

    c. In addition to implementing the activities necessary to support the Enrollee's Care Plan, as described in **Section 2.5.B.5** of the Contract, ensure the Enrollee has timely and coordinated access to primary, medical specialty, LTSS, and behavioral health care. Such additional activities shall include, but are not limited to:

        (i) Explaining PCP, specialist, and other provider directives to the Enrollee;

        (ii) Providing well-visit, medical, prenatal, outpatient behavioral health, and preventative care reminders;

        (iii) Assisting the Enrollee in scheduling health-related appointments, accessing transportation resources to such appointments, and confirming with the Enrollee that such appointments have been kept;

        (iv) Confirming with the Enrollee that they are adhering to medication recommendations;

        (v) At a minimum, conducting a face-to-face visit at home or in a location agreed upon by the Enrollee, with each Enrollee on a quarterly basis; and

(vi) Making regular telephone, telehealth, or other appropriate contact with the Enrollee between face-to-face visits.

d. Coordinating with an Enrollee's ACCS provider, if any, as follows:

(i) Inform the Enrollee's ACCS provider of all of the Enrollee's routine and specialty medical care including identifiable symptoms that may require routine monitoring;

(ii) Coordinate with the Enrollee's ACCS provider to develop the Enrollee's crisis plan to prevent use of emergency departments, hospitalizations and criminal justice involvement and to provide follow-up if these events occur; and

(iii) Coordinate with the Enrollee's ACCS provider regarding activities for improving the Enrollee's health and wellness and to allow ACCS providers to assist and reinforce the Engaged Enrollee's health and wellness goals.

e. For LTSS CPs:

(i) Coordinating with other MassHealth programs that provide Case Management. For Enrollees who (1) participate in a 1915(c) Home and Community-Based Services (HCBS) Waiver, or (2) are receiving targeted case management through DYS case managers, Adult Community Clinical Services, Community Service Agencies (CSAs) who deliver Children's Behavioral Health Initiative services, or DDS service coordinators, or (3) are receiving Community Case Management (CCM), the Enrollee's CP Care Coordinator shall coordinate the provision of LTSS CP Supports with the Enrollee's HCBS Waiver case manager, DDS service coordinator, DYS case manager, CSA and CCM, as applicable, to ensure that LTSS CP supports supplement, but do not duplicate, functions performed by HCBS Waiver case managers, DDS service coordinators, DYS case managers, CSA or CCM.

(ii) Coordinating with the Home Care Program. For Enrollees who are not in a 1915 (c) Home and Community-Based Services (HCBS) Waiver and who participate in the Home Care Program operated by the Executive Office of Elder Affairs (EOEA), the Enrollee's CP Care Coordinator shall coordinate the provision of LTSS CP supports with the Enrollee's Home Care Program case manager to ensure that LTSS CP supports supplement, but do not duplicate, functions performed by the Home Care Program case manager.

2. Obligate the Contractor to provide the CP with information pertaining to MCO Covered Services and non-MCO Covered Services, as described in **Appendix C**, including any such services requiring prior authorization or referrals; and

3. Obligate the Parties to develop, maintain, and implement a mutually agreed upon process for how the Contractor will communicate to the CP any prior authorization decisions (e.g., approval, modification or denial) about, or PCP referrals for, MCO Covered Services and non-MCO covered services.

G. Support for Transitions of Care

In addition to the requirements of **Section 2.6.C.5** of the Contract, the Parties' subcontract shall obligate the CP to:

1. Assist Enrollees who are referred to other levels of care, care management programs, or other providers, in accessing these supports. Such assistance may include, but is not limited to:

    a. Facilitating face-to-face contact between the Enrollee and the provider or program to which the Enrollee has been referred, and directly introducing the Enrollee to such provider or an individual associated with such program (i.e., "warm hand-off"), as appropriate; and

    b. Making best efforts to ensure that the Enrollee attends the referred appointment, if any, including coordinating transportation assistance and following up after missed appointments.

H. Medication Review for CP Enrollees

For CP Enrollees, the Parties' subcontract shall permit CPs to obtain a list of the Enrollee's medications and require the CP to:

1. Note in the CP Enrollee's EHR that they obtained the list; and
2. Identify the source of the list.

I. Connections to Options Counseling for Enrollees with LTSS Needs

The Parties' subcontract shall require the CP to provide information and support to each Enrollee with LTSS needs, their guardians/caregivers and other family members, as applicable, about assisting the Enrollee to live independently in their community. The Parties subcontract shall require that:

1. Such information includes, but not be limited to:

    a. Long-term services and supports;

    b. Resources available to pay for the services;

    c. The MassOptions program which can provide the Enrollee with options counseling.

2. The CP provide Enrollees support by:

    a. Assisting with referrals and resources as needed;

b. Assisting in making decisions on supportive services, including but not limited to, finding assistance with personal care, household chores, or transportation;

c. Assisting, as appropriate, in connecting to a counselor at MassOptions; and

d. Informing the Enrollee about their options for specific LTSS services and programs for which they may be eligible, the differences among the specific types of LTSS services and programs and the available providers that may meet the Enrollee's identified LTSS needs.

3. In performing this function, the CP shall document that the Enrollee was informed of multiple service options available to meet their needs, as appropriate, and reviewed and provided with access to a list of all MassHealth LTSS providers in their geographic area for each service option, when applicable.

Section 1.3 HEALTH EQUITY

The Parties' subcontract shall require the CP to collaborate with the Contractor on certain metrics and initiatives related to Health Equity, as described in **Section 2.21** of the Contract. Specifically, the Parties' subcontract shall:

A. Require the CP to collect and submit to the Contractor Enrollee-level social risk factor data (including race, ethnicity, language, disability status, age, sexual orientation, gender identity, and health-related social needs) using a screening tool and/or questionnaire provided by the Contractor when requested by the Contractor; and

B. Require the CP to support the Contractor's Health Equity initiatives, including but not limited to development of the Contractor's Health Equity Strategic Plan and Report, when such initiatives would benefit from involvement of the CP.

Section 1.4 REPORTING

The Parties' subcontract shall:

A. Obligate the Contractor to:

1. Report to its CPs monthly on monthly panel-based payments made in a form and format specified by EOHHS;

2. Report to its CPs on quality payments made, on an annual basis, and in a form and format specified by EOHHS;

3. Provide its CPs monthly assignment files as further described by EOHHS in a form and format specified by EOHHS; and

4. Provide its CPs EOHHS renewal and redetermination files.

B. Obligate the CP to:

1. Provide to the Contractor monthly Enrollment and Disenrollment files in a format specified by EOHHS;
2. Provide the Contractor data related to Health Equity as set forth in **Section 1.3.A of this Appendix P**.
3. Provide other reports to the Contractor as identified and agreed upon by both Parties.

Section 1.5 INTEROPERABILITY, RECORD KEEPING, COMMUNICATION AND POINTS OF CONTACT

A. Interoperability and Record Keeping

The Parties subcontract shall include requirements for information and data sharing, including but not limited to record keeping and changes to Enrollee's enrollment or engagement in the CP as set forth in **Section 2.6.E.10**, and shall at a minimum:

1. Obligate the Parties to enter into and maintain an agreement governing the CP's use, disclosure, maintenance, creation or receipt of protected health information (PHI) and other personal or confidential information in connection with the subcontract that satisfies the requirements for a contract or other arrangement with a Business Associate under the Privacy and Security Rules, includes any terms and conditions required under a data use agreement between the Contractor and EOHHS and otherwise complies with any other privacy and security laws, regulations and legal obligations to which the Contractor is subject;
2. Include such agreement as an appendix to the subcontract;
3. Specify that no Party to the subcontract may obligate the other Party to use a specific Information Technology, Electronic Health Record system, or Care Management system;
4. Obligate both Parties to develop, maintain, and implement a mutually agreed processes for the exchange of Enrollee data between the Parties;
    a. Specify the elements included in such data exchange, which shall include at a minimum: Enrollee name; date of birth; MassHealth ID number; MassHealth Assignment Plan; Enrollee address and phone number; Enrollee Primary Language (if available); and PCP name, address, and phone number;
    b. Specify the frequency of such data exchange, which shall not be less than monthly;
    c. Specify the file type of such data exchange (e.g., Excel file or other mutually agreed upon file type);
    d. Specify the secure transmission method (e.g., secure email or the Mass HIway).

5. Obligate both Parties to develop and implement requirements around record keeping, including that:

    a. The CP shall maintain an information system for collecting, recording, storing and maintaining all data required under the Contract.

    b. The CP shall maintain a secure Electronic Health Record for each Enrollee that includes, but is not limited to, a record of:

        (i) All applicable Comprehensive Assessment and Care Plan elements, as described in **Sections 1.2.B** and **1.2.C** of this **Appendix P**;

        (ii) A timely update of communications with the Enrollee and any individual who has direct supportive contact with the Enrollee (e.g., family members, friends, service providers, specialists, guardians, and housemates), including, at a minimum:

            (a) Date of contact;

            (b) Mode of communication or contact;

            (c) Identification of the individual, if applicable;

            (d) The results of the contact; and

            (e) The initials or electronic signature of the Care Coordinator or other staff person making the entry.

        (iii) Enrollee demographic information.

    c. The CP shall ensure that all Enrollee Electronic Health Records are current and maintained in accordance with this Contract and any standards as may be established from time to time by EOHHS; and

    d. The CP shall provide the Contractor with a copy of the Enrollees' Electronic Health Records within thirty (30) calendar days of a request.

6. Obligate both Parties to develop, maintain, and implement a mutually agreed upon process for changes to Enrollee enrollment or engagement with the CP, including:

    a. Specify the Contractor's process for processing requests from Enrollees to enroll in a different CP or disengage from the CP;

    b. Specify the process by which the Contractor, in consultation with the CP, will determine if CP supports are no longer necessary for an Enrollee; and

c. Specify the form, format and frequency for communications between the Parties regarding changes to Enrollee enrollment or engagement and the processes for transitioning such Enrollee's care coordination.

7. The Parties' subcontract shall require that the CP maintain a record of Qualifying Activities performed for each Enrollee as further specified by EOHHS.

B. Communication and Points of Contact

The Parties' subcontract shall include requirements for communication and identification of points of contact, and shall at a minimum:

1. Obligate both Parties to establish key contact(s) who will be responsible for regular communication between the Parties about matters such as, but not limited to, data exchange, and care coordination, as described in **Section 2.6.E.12** of the Contract.
2. Obligate both Parties to provide the other Party information about key contact(s), including at a minimum the key contact's name, title, organizational affiliation, and contact information;
3. Obligate both Parties to provide each other with timely notification if such key contact(s) change; and
4. Obligate both Parties to develop, implement, and maintain a mutually agreed upon process for reporting of gross misconduct or critical incident involving an Enrollee to each other, as described in this **Appendix P**. The Parties' subcontract shall require the CP to develop, implement, maintain, and adhere to procedures to track, review, and report critical incidents. The procedures shall:

    a. Be jointly developed

    b. Require the CP to document critical incidents including:

        (i) Fatalities and near fatalities;

        (ii) Serious injuries;

        (iii) Medication-related events resulting in significant harm;

        (iv) Serious employee misconduct;

        (v) Serious threats of harm to Enrollees, CP employees or others;

        (vi) Require the CP to report critical incidents to the Contractor and the appropriate agencies and authorities;

    c. Require the CP to designate key personnel to track, report and monitor critical incidents;

d. Require the CP to review critical incidents by committee which includes a Medical Director and Clinical Care Manager, at least quarterly; and

e. Require the CP to take proactive steps to modify processes to avoid future incidents.

Section 1.6 PERFORMANCE MANAGEMENT AND CONFLICT RESOLUTION

The Parties' subcontract shall include requirements for performance management and compliance as set forth in **Section 2.6.E.3** of the Contract, as well as for conflict resolution. The Parties' subcontract shall, at a minimum:

A. Include a mutually agreed upon process for continued management of the subcontract, including:

1. Specifying the frequency and format of regular meetings between the Parties for the purposes of discussing the Parties' compliance under the Parties' subcontract; and
2. Specifying the intended topics of discussion during such meetings, which may include topics such as, but not limited to, Enrollee outreach, engagement, cost, utilization, quality and performance measures, communication between the Parties, and Enrollee grievances.
3. Include a mutually agreed upon process for conflict resolution to address and resolve concerns or disagreements between the Parties which may arise, including but not limited to clinical, operational and financial disputes.
4. Outline a mutually agreed upon process for CP performance management that may include but is not limited to the following set of escalating steps: development and implementation of a performance improvement plan, development and implementation of a corrective action plan, non-compliance letter, and contract termination. Such process for performance management shall:

    a. Specify the areas in which the Contractor shall monitor CP performance and relevant data sources for such monitoring

    b. Specify the areas in which the Contractor shall engage in performance management of the CP, which must include: fidelity to CP Supports as outlined in the Parties' subcontract, critical incident reporting, grievances, record keeping, and other responsibilities or performance indicators outlined in the Parties' subcontract.

5. Obligate both Parties to develop processes relating to the types, frequency, and timeliness of bidirectional reports on performance, outcomes, and other metrics;
6. Obligate both Parties to establish a cadence for the Parties' leadership to engage on the output of such reports, in order to identify and jointly agree upon areas to improve Enrollee care and performance on financial, quality, and utilization goals, including specifications on who will be responsible for engaging with such reports.

Section 1.7 ENROLLEE PROTECTIONS

A. Grievances

The Parties' subcontract shall require that the CP develop, implement, maintain, and adhere to written policies and procedures for the receipt and timely resolution of Grievances from Enrollees. Such policies and procedures shall require the CPs to:

1. At least annually, the CP shall notify the Contractor of any grievances the CP received and the resolution of the grievance.
2. At least annually, the Contractor shall notify EOHHS of any grievances the CP or Contractor has received regarding the CP program and the resolution of the grievance.

B. Information and Accessibility Requirements

The Parties' subcontract shall require that:

1. With respect to any written information it provides to Enrollees, the CP make such information easily understood as follows:
    a. Make such information available in prevalent non-English languages specified by EOHHS;
    b. Make oral interpretation services available for all non-English languages, including American Sign Language, available free of charge to Enrollees and notify Enrollees of this service and how to access it; and
    c. Make such information available in alternative formats and in an appropriate manner that takes into consideration the special needs of Enrollees, such as visual impairment and limited reading proficiency, and notify Enrollees of such alternative formats and how to access those formats.
2. The CP ensures that Enrollee visits with Care Coordinators are conducted in a manner to accommodate an Enrollee's disability and language needs, including the use of safe and accessible meeting locations, language assistance (e.g., access to qualified interpreters), and auxiliary aids and services (e.g., documents that are accessible to individuals who are blind or have low vision).

C. Enrollee Rights

The Parties' subcontract shall require that the CP have written policies ensuring Enrollees are guaranteed the rights described in **Section 5.1.L** of the Contract, and ensure that its employees, Affiliated Partners, and subcontractors observe and protect these rights. The CP shall be required to inform Enrollees of these rights upon Enrollees' agreement to participate in the CP program.

Section 1.8 OMBUDSMAN

The Parties' subcontract shall require that the CP supports Enrollee access to, and work with, the EOHHS Ombudsman to address Enrollee requests for information, issues, or concerns related to the CP or MCO program, as described in **Section 2.13.A.8** of the Contract.

Section 1.9 TERMINATION

A. The Contractor's subcontract shall, at minimum:

1. Obligate both Parties, prior to termination of the subcontract by either Party, to:

    a. Follow all conflict resolution processes, as appropriate, described in this **Appendix P**;

        (i) Provided however that if both Parties agree to terminate the subcontract for reasons other than for-cause, the Parties may terminate the subcontract without following all conflict resolution processes described in this **Appendix P**;

    b. If EOHHS terminates the relevant contract with the Contractor or CP, termination of the subcontract may be made without following all conflict resolution processes described in this **Appendix P**; and

    c. If EOHHS notifies a Party to the subcontract, indicating that the other Party has materially breached its contract with EOHHS, in the sole determination of EOHHS, the first Party may terminate the subcontract without following all conflict resolution processes described in this **Appendix P**;

2. Specify that in the event of termination of the subcontract, the obligations of the Parties under the subcontract, with regard to each shared Enrollee at the time of such termination, will continue until the CP has provided a warm hand-off of the Enrollee to the Contractor, a new MCO or ACO, or a new CP, if applicable, and the transition of Enrollee data in accordance with the Parties' data policies, provided, however, that the Parties shall exercise best efforts to complete all transition activities within one month from the date of termination, expiration, or non-renewal of the subcontract.

Appendix Q

EOHHS Managed Care Organization Quality and Health Equity Appendix

This Appendix details how EOHHS will determine the Contractor's Quality and Health Equity Performance as described in the Contract. EOHHS may modify the methodology set forth herein after the execution of the Contract by written amendment. The following information is included. For the purposes of this document, "Performance Year" or "PY" shall mean "Contract Year" as defined in Section 1 of the Contract, unless otherwise specified by EOHHS.

1 Overview of Quality Performance and Scoring and Health Equity Performance and Scoring

The Contractor shall receive, for each Performance Year, an MCO Quality Score that shall determine the Quality Incentive payment amount available to the Contractor as prescribed in **Sections 2.14** and **4.6.B** of the Contract. The Contractor shall also receive, for each Performance Year, an MCO Health Equity Score that shall determine the Quality and Equity incentive payment amount available to the Contractor as prescribed in **Sections 2.21** and **4.6.C** of the Contract. The Contractor shall also receive, for each Performance Year, a CP Quality Score (calculated by EOHHS) for each Community Partner subcontractor as described in **Section 2.6.E** of the Contract. The CP Quality Score shall be used in the determination of incentive payments made by the Contractor to each of its subcontracted CPs.

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

2 Scoring Methodology for MCO Quality Score

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

EOHHS, at its discretion, may also implement a pay-for-reporting component added to the overall MCO Quality Score methodology. As further specified by EOHHS, this component may include benchmarks or other requirements pertaining to the calculation/reporting of electronic-based quality measures (e.g., ECDS, eCQM) beginning with PY2023.

2.a List of Quality Measures for MCO Quality Score

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

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

See Exhibit 2 for the list of Quality Measures.

EXHIBIT 2 – MCO Quality Measures

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

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
	Topical Fluoride for Children, Dental or Oral Health Services	Percentage of children aged 1–20 years who received at least 2 topical fluoride applications as dental or oral health services within the reporting year	Claims	ADA DQA	3700	2024

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0	P4P Transition Year
Care Coordination/ Care for Acute and Chronic Conditions	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 days	Claims	NCQA	3489	Yes	2023
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	Percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who has a follow up visit for AOD	Claims	NCQA	3488	No	2023
	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576	Yes	2023

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	Included in Waiver 1.0	P4P Transition Year
	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose blood pressure was adequately controlled	Hybrid	NCQA	0018	Yes	2024
	Comprehensive Diabetes Care: HBA1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059	Yes	2024
	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800	Yes	2024
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004	Yes	2024
Member Experience	Overall Care Delivery	Composites related to overall experience (e.g., Willingness to Recommend, Communications)	Survey	AHRQ	N/A	Yes	2023
	Person-Centered Coordination/Integration of Care	Composites related to coordination of care (e.g., referrals, services etc.) and knowledge of the patient	Survey	AHRQ	N/A	Yes	2023

2.b Measure Level Scoring Methodology (Achievement and Improvement Points)

1. Achievement Points

The Contractor may receive up to a maximum of ten (10) achievement points for each Quality Measure, as follows:

1. EOHHS will establish an "attainment threshold" and a "goal benchmark" for each Quality Measure
    a. "Attainment threshold" sets the minimum level of performance at which the contractor can earn achievement points
    b. "Goal benchmark" is a high performance standard above which the Contractor earns the maximum number of achievement points (i.e., 10 points)
2. EOHHS will calculate the Contractor's performance score on the Quality Measure based on the measure specifications
3. EOHHS will award the Contractor between zero (0) and ten (10) achievement points as follows:
    a. If the Contractor's performance score is less than the attainment threshold: 0 achievement points
    b. If the Contractor's performance score is greater than or equal to the goal benchmark: 10 achievement points
    c. If the performance score is between the attainment threshold and goal benchmark: achievement points earned are determined by the formula:
        i. 10*((Performance Score – Attainment Threshold) / (Goal Benchmark – Attainment Threshold))

EXHIBIT 3 – Example Calculation of Achievement Points for Measure A

Measure A attainment threshold = 45% (e.g., corresponding to 25th percentile of HEDIS benchmarks) **Measure A goal benchmark** = 80% (e.g., corresponding to 90th percentile of HEDIS benchmarks)
Scenario 1:
• Measure A performance score = 25%
• Achievement points earned = 0 points
Scenario 2:
• Measure A performance score = 90%
• Achievement points earned = 10 points
Scenario 3:
• Measure A performance score = 60%
• Achievement points earned = 10*((60% - 45%) / (80% - 45%)) = 4.29 points

2. Improvement Points

In addition to receiving achievement points based on performance (on a 0 to 10 scale), the Contractor may earn improvement points for reaching established improvement targets for each Quality Measure. Improvement points will be calculated as follows:

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

2. Beginning PY2, EOHHS will compare the Contractor's performance score on each Quality Measure to the Contractor's performance score on that same Quality Measure from the highest scoring previous Performance Year.

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

    a. Improvement Target formula = [(Goal Benchmark –Attainment Threshold) /5]

For example, for Measure A, if the Attainment Threshold is 50% and the Goal Benchmark is 60%, the Improvement Target is 2% [(60 – 50)/5)]

    b. For the purposes of calculating the Improvement Target, the result is rounded to the nearest tenth (i.e., one decimal point).

For example, for Measure B, if the Attainment Threshold is 80% and the Goal Benchmark is 90.2%, the Improvement Target is calculated to 2.04% [(90.2 – 80)/5)] which rounds to 2.0%.

    c. The Contractor may earn up to five (5) improvement points for increases in measure score which <u>meet or exceed</u> the improvement target.

For example, for Measure B, the Improvement Target is 2.0%. If Contractor performance in PY4 is 54.0% and if Contractor performance in PY5 is 60.0%, the Contractor improvement from PY4 to PY5 is 6.0% [(60.0-54.0)] and the Contractor is awarded 5 improvement points. No points above 5 are awarded for increases in excess of the improvement target.

    d. For the purposes of calculating the difference in Contractor quality performance over a previous year, the results are rounded to the nearest tenth (i.e., one decimal point). Rounding takes place after the calculation.

For example, for Measure B, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 60.17%, the Contractor improvement from PY4 to PY5 is 5.63% [(60.17-54.54)], and the Contractor improvement will be rounded to the nearest tenth (i.e., one decimal point) to 5.6%.

    e. The Improvement Target is based on the ***<u>higher</u>*** of the original baseline or any year's performance prior to the current PY. This is intended to avoid rewarding regression in performance.

For example, for Measure B, assume Contractor performance in PY1 is 90.0% and the Improvement Target is 2.0%. If in PY4 the performance for the Contractor decreases to 89.0%, in PY5 the Contractor would need to reach 92.0% to reach the Improvement Target.

    f. There are several special circumstances:

i. *At or Above Goal:* If the Contractor has prior PY performance scores equal to or greater than the Goal Benchmark then the Contractor may still earn up to five (5) improvement points in each PY if improvement from the highest prior PY is greater than or equal to the Improvement Target.

ii. *At or Below Attainment:* If the Contractor has prior PY performance scores less than the Attainment Threshold then the Contractor may still earn up to five (5) improvement points each PY if improvement from the highest prior PY is greater than or equal to the Improvement Target, and performance in the current PY does not equal or exceed the Attainment Threshold. Additionally, if the Contractor has prior PY performance scores less than the Attainment Threshold and current PY performance scores are equal to or above the Attainment Threshold then the Contractor may still earn up to five (5) improvement points if the improvement is greater than or equal to the Improvement Target.

EXHIBIT 4 – Example Calculation of Improvement Points for Measure B

Measure B Attainment = 48.9% | Goal = 59.4% | Improvement Target = 2.1%

	PY4 Score	PY5 Score	Improvement	Improvement Target Met	Improvement Points Earned
Scenario 1:	50.0%	52.1%	2.1%	Yes	5
Scenario 2:	50.0%	56.7%	6.7%	Yes	5
Scenario 3:	59.5%	63.0%	3.5%	Yes; above Goal Benchmark	5
Scenario 4	45.0%	48.0%	3.0%	Yes; below Attainment Threshold	5
Scenario 5:	46.0%	49.0%	3.0 %	Yes; crossing Attainment	5
Scenario 6:	45.0%	46.0%	1.0%	No	0

2.c Domain Level Scoring Methodology

EOHHS will sum the Contractor's achievement and improvement points for all Quality Measures within each Quality Domain. Improvement points earned in one Quality Domain may only be summed with achievement points from the same Quality Domain. The total number of points earned by the Contractor in each domain cannot exceed the maximum number of achievement points available in the domain. The maximum number of achievement points in the domain is calculated by multiplying the number of Pay-for-Performance (P4P) measures in the domain, in the given PY, by the number of available achievement points per measure.

For example, if in PY4, there are ten (10) clinical quality measures in Domain X in Pay-for-Performance, and each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 100. Assume that in PY5 there are now twelve (12) clinical quality measures in Domain

X in Pay-for-Performance, and that each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 120.

Cumulative Example:
Total number of measures in domain: 2
Maximum number of achievement points in the domain = 20
Measure Attainment = 48.9% | Goal = 59.4%
Improvement Target = [(Goal Benchmark –Attainment Level) /5] = [59.4-48.9]/5 = 2.1

For example, for Measure A, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 58.17% the Contractor will earn 8.8 Achievement Points [10 * (58.17 – 48.9)/(59.4 – 48.9)]. The Contractor has improved from PY4 to PY5 by 3.63% [(58.17 - 54.54)] which will be rounded to the nearest tenth (e.g., one decimal point) to 3.6% which exceeds the Improvement Target of 2.1%. Thus, the Contractor will earn five (5) improvement points. No points above 5 are awarded for increases in excess of the improvement target.

In this scenario the Contractor would earn 13.8 points.

If there is only one (1) additional measure in the Domain and the Contractor earned 9 total points for this measure; the total score for the Contractor would be 20.0 (out of 20) given that domain scores are capped at the maximum number of achievement points (20) in the domain.

Once the total number of points has been calculated, EOHHS will divide the resulting sum by the maximum number of achievement points that the Contractor is eligible for in the domain to produce the Contractor's Domain Score. Domain Scores are a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). EOHHS will score the Contractor on each P4P Quality Measure unless the Contractor does not meet eligibility requirements for a specific measure (e.g., it does not meet the minimum denominator requirement). In cases like this, the measure is not factored into the denominator. Reporting measures do not factor into the Domain Score. Additionally, improvement points do not count towards the denominator; they are therefore "bonus" points. Domain Scores are each capped at a maximum value of 100%.

EXHIBIT 5 – Example Calculation of an Unweighted Domain Score

Example Calculations of Unweighted Domain Score		
Example 1	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 1.5
		Improvement Points: 0
	Measure B:	Achievement points: 0
		Improvement Points: 5
	Total achievement points: 1.5 + 0 = 1.5 points	
	Total improvement points: 0 + 5 = 5 points	
	Sum of achievement and improvement points: 1.5 + 5 = 6.5 points	
	Unweighted domain score = 6.5/20 * 100 = 32.5%	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)	

	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 8
		Improvement Points: 5
	Measure B:	Achievement points: 9.3
		Improvement Points: 0
	Total achievement points: 8 + 9.3 = 17.3	
	Total improvement points: 5 points	
	Sum of achievement and improvement points: 17.3 + 5 = 22.3 points	
	However, total number of points cannot exceed maximum number of achievement points (20)	
	Therefore, total domain points = 20	
	Unweighted domain score = 20/20 * 100 = 100%	

3 Scoring Methodology for MCO Quality & Equity Incentive Program (QEIP) Health Equity Score

1. Performance Year 1 (CY2023) requirements for the MCO QEIP can be found in Attachment 1 to this Appendix.
2. Performance Years 2-5 (CY2024-2027) requirements for the MCO QEIP are forthcoming and will be provided in Attachment 2 to this Appendix.

4 Scoring Methodology for Community Partners Quality Score

EOHHS shall calculate a Community Partner Quality Score for each of the Contractor's subcontracted CPs. Community Partner Quality Scores are based on the performance of each subcontracted CP's MassHealth enrollment, as determined by EOHHS, across a set of benchmarks or improvement targets for individual measures within the BH CP or LTSS CP measure slate as applicable as set forth in Exhibits 5 and 6 below. EOHHS will weight each CP's CP Quality Score by the volume of that CP's enrollment within the MCO relative to the volume of all other CP subcontractors within the same MCO. As further specified by EOHHS, EOHHS shall use the weighted CP Quality Score to determine the Contractor's payment to each CP based on the CP's quality performance. In addition to the above methodology, EOHHS may establish additional quality incentives designed to reward the Contractor's higher performing subcontracted CPs.

4.a Quality Measures for CP Quality Score

Exhibit 6 – BH CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.
Follow-up with BH CP after acute or	Percentage of discharges from acute or post-acute stays for	Claims	EOHHS	NA

Measure Name	Description	Data Source	Measure Steward	NQF No.
post-acute stay (x days)	enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP within x business days of discharge			
Follow-up with BH CP after ED visit (x days)	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within x days of the ED visit	Claims	EOHHS	NA
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA
Initiation/Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	Claims	NCQA	1932
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment	Claims	NCQA	0105

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

Exhibit 7 – LTSS CP Quality Measures

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

5 Methodology for Establishing Performance Benchmarks for Quality Measures

EOHHS will establish the attainment threshold, goal benchmark, improvement target (and/or any other applicable performance indicator) for each Quality Measure applicable to MCO Quality and MCO Health Equity, and CP Quality scoring methodologies. EOHHS anticipates establishing these performance indicators as follows:

- For Quality Measures based on NCQA HEDIS measures, EOHHS anticipates using NCQA Quality Compass percentiles, as well as MassHealth historical MCO and Community Partners' performance
- For non-HEDIS Quality Measures, EOHHS anticipates using MassHealth historical MCO and Community Partners' performance
- For other Quality Measures where EOHHS does not have access to applicable data, EOHHS anticipates using MassHealth benchmarks based on MCO/CP-attributed populations

6 Quality Performance Financial Application

The Contractor's MCO Quality Score and MCO Health Equity Score will be applied to performance incentive payment as described in **Section 4.6.** Community Partner Quality Scores will be applied to incentive payments to CP subcontractors as described in **Section 2.6.E.**

Attachment 1: MassHealth "MCO Quality and Equity Incentive Program" Performance Year 1 Implementation Plan

Table of Contents

Section 1. Background and Overview of the Managed Care Organization Quality and Equity Incentive Program

A. Overview

Massachusetts shifted the delivery system at scale to value-based care under the previous MassHealth section 1115 demonstration approval period, transitioning over 80 percent of eligible Medicaid members into accountable care organizations (ACOs) that are at risk to deliver better health outcomes, lower cost, and improved member experience through integrated, coordinated care.

A key goal of the Commonwealth's in this demonstration period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system.

To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings including but not limited to MassHealth's Managed Care Organizations (MCOs), Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (together "ACOs"), managed behavioral health vendor, and acute hospitals.

Together, this constellation of coordinated quality and equity initiatives will support Massachusetts in achieving its demonstration goal to improve quality of care and advance health equity.

B. Scope of this Implementation Plan

This Performance Year 1 Implementation Plan provides additional detail related to implementation of MassHealth's MQEIP for the first MCO PY from April 1, 2023-December 31, 2023 of the MCO contract (April 1, 2023 – December 31, 2027.) Information pertaining to PYs 2-5, representing Calendar Years 2024-2027, will be forthcoming.

Section 2: Managed Care Organization Quality and Equity Incentive Program (MQEIP) Domains and Goals

A. Overview of Targeted Domains for Improvement in the MQEIP

For the MQEIP, MCOs are incentivized to pursue performance improvements in the domains specified in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the MQEIP

Domain 1: Demographic and Health-Related Social Needs Data	Managed Care Organizations will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth's data requirements. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element.
Domain 2: Equitable Quality and Access	Managed Care Organizations will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or limited English proficiency; preventive, perinatal, and pediatric care services; care for chronic diseases and behavioral health; and care coordination.
Domain 3: Capacity and Collaboration	Managed Care Organizations will be assessed on improvements in metrics such as provider and workforce capacity and collaboration within health system providers (e.g. clinical partners) to improve quality and reduce health care disparities.

B. Goals for each Domain of the MQEIP

Goals for each MQEIP domain are summarized below:

1. Demographic and Health-Related Social Needs Data Collection Domain Goals

a. MCOs are incentivized to achieve certain milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data for attributed MassHealth members by the end of Performance Year 3 (CY 2025).

b. MCOs are incentivized to achieve certain milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least primary language, disability status, sexual orientation, and gender identity) for attributed MassHealth members by the end of Performance Year 5 (CY 2027).

c. MCOs are incentivized to meaningfully improve rates of HRSN screenings from the baseline period (CY 2024 and/or CY 2025) by the end of Performance Year 5 (CY 2027). To meet this goal, MCOs must not only conduct screenings of beneficiaries, but also establish the capacity to track and report on screenings and referrals.

2. Equitable Quality and Access Domain Goals

a. MCOs are incentivized for performance on metrics such as those related to access to care (including for individuals with limited English proficiency and/or disability); preventive, perinatal, and pediatric care; care for chronic diseases; behavioral health; care coordination; and/or patient experience.
b. For up to the first three Performance Years (PY 2023 through PY 2025), MCO performance will be based on:
    i. Reporting on access and quality metric performance, including reports stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health related social needs; and/or defined by other individual- or community-level markers or indices of social risk;
c. For at least the last two Performance Years (PY2026 and PY2027), MCO performance will be based on improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

3. Capacity and Collaboration Domain Goals

MCOs are incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider cultural competence and achievement of externally validated equity standards.

Section 3: MQEIP Performance Year 1 Metrics

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year health equity goals, the first performance year of the MQEIP holds MCOs accountable to metrics listed in Table 2 evaluating contributory health system level interventions in each performance domain.

Table 2. MQEIP Performance Year 1 Metrics

Subdomain	**Metric (*Steward)***	**Performance Year 1 status***
Domain 1. Demographic and Health-Related Social Needs Data		

Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Pay for Reporting (P4R)
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*): Preparing for Reporting Beginning in PY2	P4R
Domain 2. Equitable Access and Quality		
Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	P4R
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	P4R
	Disability Competencies (*EOHHS*)	P4R
	Accommodation Needs Met *(EOHHS)*	P4R
Domain 3. Capacity and Collaboration		
Capacity	To Be Determined Pending Further Guidance (*NCQA*)	P4R

*Reporting/performance requirements for each measure described in relevant metric technical specifications

Recognizing that taking on accountability for equity is new for most MCOs, interim and annual goals for Performance Year 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in Performance Year 2-5. Summarized performance expectations are described in Table 3; detailed performance expectations are described in metric technical specifications.

Table 3. Summary of MQEIP Metric Performance Requirements Performance Year 1

Metric	Performance Expectations for Performance Year 1	Anticipated Deadline
Domain 1. Demographic and Health-Related Social Needs Data		
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity	• **Race, Ethnicity, Language, Disability status (RELD) Sexual Orientation, Gender Identity (SOGI) Assessment** – Timely and complete submission to EOHHS of an initial assessment of 1) beneficiary-reported demographic data adequacy and	July 31, 2023

Data Completeness (*EOHHS)*	completeness, and 2) a plan for collecting demographic data including data sources and collection questions. • Complete and timely submission to the MassHealth Data Warehouse (DW) of monthly Member Files as specified (beginning no later than Q4 2023). The DW will reject monthly Member File submissions that are non-compliant with the specified format (e.g. previously compliant formats) after Q4 2023. • Data collected by MCOs will be submitted via the existing encounter submission process, using the enhanced Member File Specification.	Beginning no later than Q4 2023
Screening for Social Drivers of Health (*CMS): Preparing for Reporting Beginning in PY2*	• **Health-Related Social Needs (HRSN) Assessment** – Timely and complete submission to EOHHS of an initial assessment of 1) beneficiary-reported HRSN data adequacy and completeness, and 2) strategies employed to provide information about referrals including to community resources and support services. • Complete and timely submission of a report to EOHHS describing: 1) One or more health-related social needs screening tool(s) selected by the MCO for intended use in screening members beginning in PY2; the selected tool(s) must meet requirements for screening tools for the "Screening for Social Drivers of Health" metric and Section 2.5 of the MCO Contracts; and 2) An implementation plan to begin screening for health-related social needs in Q1 2024 in order to have capacity to report on the "Screening for Social Drivers of Health" metric beginning in Performance Year 2. 3) Develop strategies employed to provide information about	July 31, 2023 October 27, 2023

	community resources and support services available to members who screen positive for HRSNs. 4) An implementation plan describing how the MCO will ensure members enrolled in the Community Partners (CP) program are screened for HRSNs, including how contracted CPs will document screenings, how the CPs will notify the MCO when the screening is conducted, and how the CP will communicate results of the screening with the MCO.	
Domain 2. Equitable Access and Quality		
Stratified Reporting of Quality Data (*EOHHS*)	Complete and timely submission to EOHHS of performance data, including member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Quality Incentive Arrangement measure slate.	No sooner than April 1, 2024
Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	Complete and timely reporting of an organizational self-assessment of capacity related to providing access to high quality language services to members.	December 31, 2023

Disability Competencies (*EOHHS*)	• Complete and timely submission to EOHHS of the MCO's DCC Team's completed RIC **Disability-Competent Care Self-Assessment Tool (DCCAT)** report • **Disability Competency Self-Assessment** – Timely and complete submission to EOHHS of a report on the results of the disability competencies self-assessment, including identified disability competencies targeted for improvement in PY 2.	December 1, 2023

Accommodation Needs Met (*EOHHS)*	Complete and timely submission to EOHHS of a report describing the MCO's current practice and future plans for the following: • Screening members for accommodation needs* before or during an outpatient encounter, and how the results of this screening is documented. • Other methods, if any, for documenting accommodation needs. • Asking members to report, during or after an outpatient encounter, if their accommodation needs were met. • Analyses that are performed at the organizational level to understand whether accommodation needs have been met. **For this report, accommodation needs are regarded to be needs related to a disability, including disabilities as a result of a physical, intellectual or behavioral health condition. For this report, this does not include needs for language interpreters, but does include accommodation needs for vision impairments (e.g., Braille) or hearing impairments (e.g., ASL interpreters).*	December 1, 2023
Domain 3. Capacity and Collaboration		
Achievement of External Standards for Health Equity (*EOHHS)*	*Pending Further Guidance From NCQA*	December 31, 2023

Section 4: MQEIP Payment for Performance Year 1

EOHHS will pay each MCO based on the MCO's health equity score in accordance with Section 4.6 of the MCO Contract. EOHHS will make a one-time payment to the MCO after the health equity score has been finalized.

Section 5: MQEIP Accountability Framework for Performance Year 1

EOHHS will hold each MCO individually accountable for its performance on the MQEIP performance measures. Total incentive amounts for each MCO for Performance Year 1 will be distributed according to the weighting described in Table 4. Performance expectations for each metric are summarized in Table 3 above and detailed further in technical specifications.

The Performance Year 1 Health Equity Score will be determined by EOHHS's assessment of completeness and timely submission of deliverables associated with each performance measure. The total Health Equity Score will be calculated according to the weights outlined in Table 4 below, with performance on each metric measured by the degree to which the MCO met performance requirements summarized in Table 3, as determined by EOHHS.

Table 4. Performance Year 1 MQEIP Metric Weights

Subdomain	MCO Quality and Equity Incentive Program Metric (*Steward)*	Performance Year 1 Weight (%)
Domain 1. Demographic and Health-Related Social Needs Data		**25**
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	15
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*)	10
Domain 2. Equitable Access and Quality		**50**
Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	15
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	15
	Disability Competencies (*EOHHS*)	10
	Accommodation Needs Met (EOHHS)	10
Domain 3. Capacity and Collaboration		**25**
Capacity	Pending Further Guidance From NCQA	25

Appendix S

Directed Payments Related to Certain MCO Covered Services

Exhibit 1: HCBS Temporary Rate Increases by Service

Exhibit 1A Summary of HCBS Rate Increases

Covered Service	Increase	Rate Increase Effective Date	Rate Increase End Date
Independent nurses / Continuous Skilled Nursing services provided to Special Kids Special Care enrollees	10%	4/1/23	6/30/23
Home Health Services	10%	4/1/2023	6/30/2023

The Contractor shall refer to the following MassHealth Provider Manual sections for additional detail on applicable codes for each service:

- https://www.mass.gov/doc/independent-nurse-in-subchapter-6-0/download
- https://www.mass.gov/doc/home-health-agency-hha-subchapter-6/download
- www.mass.gov/doc/continuous-skilled-nursing-agency-csn-subchapter-6-0/download

Exhibit 2: Summary of Behavioral Health Services Rate Increases by Service

Covered Service*	Increase	Rate Increase Effective Date	Rate Increase End Date
Acute Treatment Services (ATS) for Substance Use Disorders and Clinical Support Services for Substance Use Disorders (including Individualized Treatment Services)	10%	4/1/2023	6/30/2023
Community-Based Acute Treatment for Children and Adolescents (CBAT), including Autism CBAT	10%	4/1/2023	6/30/2023
Intensive Outpatient Program (IOP)	10%	4/1/2023	12/31/2023
Partial Hospitalization (PHP)	10%	4/1/2023	12/31/2023
Program of Assertive Community Treatment (PACT)	10%	4/1/2023	6/30/2023
Psych Day Treatment	10%	4/1/2023	9/30/2023
Psychological Testing	10%	4/1/2023	6/30/2023
Residential Rehabilitation Services for Substance Use Disorders, including Adult Residential, Transitional Age Youth and Young Adult Residential, Youth Residential, and Pregnancy Enhanced Residential	10%	4/1/2023	6/30/2023
Structured Outpatient Addiction Program (SOAP)	10%	4/1/2023	6/30/2023

Covered Service*	Increase	Rate Increase Effective Date	Rate Increase End Date
Transitional Care Unit (TCU)	10%	4/1/2023	12/31/2023

For Residential Rehabilitation Services (RRS), Acute Treatment Services (ATS), Clinical Stabilization Services (CSS), Program of Assertive Community Treatment (PACT), 60-minute Psychotherapy codes, and Psychiatric Day Treatment (Behavioral Health Day Treatment), the Contractor shall apply the percentage increases to contracted rates effective as of July 1, 2021.

For dates of service on or after February 1, 2022, for Behavioral Health Urgent Care (BHUC), the Contractor shall apply the percentage increases to contracted rates effective as of February 1, 2022. The percentage increase will be in addition to the BHUC directed payment set forth in managed care plan contracts.

For all other services, the Contractor shall apply the percentage increases indicated in the table to the plan's contracted rates with providers as of June 30, 2021.

ATTACHMENT 1

SPECIAL KIDS SPECIAL CARE PROGRAM

EXHIBITS:

Exhibit A: Criteria to Participate in the SKSC Program

Exhibit B: Cities and Towns in each Region for SKSC Program

Exhibit C: SKSC Capitation Rate and Risk Sharing Arrangement Information

Exhibit D: SKSC Capitation Rates for Contract Year 2020

SECTION 1. DEFINITIONS

The following terms shall have the meaning stated as described hereunder, unless the context clearly indicates otherwise. Other capitalized terms shall have the meanings set forth in the MCO Contract.

Attachment 1: this Attachment for the Special Kids Special Care Program.

Child in the Care or Custody of the Massachusetts Department of Children and Families (DCF): a child placed in the custody of DCF through court order or through adoption surrender.

Complex Care Management: the implementation of individualized Care Management services to Enrollees with complex health care needs (physical, behavioral health and/or social) as defined in Attachment 1. Complex Care Management shall be consistent with the care delivery, care coordination, and care management requirements set forth in **Section 2.5** and **Section 2.6** of the MCO Contract.

Complex Care Management Coordinator (CCMC): the individual with primary responsibility for coordinating and managing all aspects of a SKSC Enrollee's Complex Care Management needs. The Complex Care Management Coordinator position may be assumed by a Pediatric Nurse Practitioner, a Physician's Assistant, or by a Registered Nurse who shall be supervised by a Pediatric Nurse Practitioner.

DCF Caseworker: an individual, employed by DCF or one of its contracted provider agencies, who assists DCF clients and their families access necessary social, educational, medical, and other services.

DCF Health and Medical Services Team (HMST): a multidisciplinary team that supports the medical and healthcare needs of children in DCF care or custody across the state; provides assistance and consultation to DCF staff statewide; identifies healthcare and medical issues that need to be addressed through DCF policy and practice and works with DCF staff to develop, revise, and implement policies and procedures; and collaborates with DCF staff and medical practitioners to help ensure that children receive all necessary primary and specialty care in the most appropriate setting.

Disenrollment Date: up to 11:59 p.m. on the last day, as determined by EOHHS, on which the Contractor is responsible for providing services under Attachment 1 to a SKSC Enrollee.

Enrollment Date: as of 12:01 a.m. on the first day, as determined by EOHHS, on which the Contractor is responsible for providing services under Attachment 1 to a SKSC Enrollee.

EOHHS Liaison: an employee of EOHHS assigned to oversee the management of the SKSC Program.

Individual Care Plan (ICP): a holistic individualized plan of care (i.e., to include medical, behavioral health, and social needs) developed by the SKSC Enrollee's Complex Care Management Coordinator, in collaboration with the DCF Caseworker, Enrollee's PCP, and any additional health care providers.

MCO Contract: the contract between EOHHS and the Contractor, to which this Attachment 1 is an attachment, and any amendments thereto, for the provision of managed care services to MassHealth Members through the Contractor's Plan.

MCO SKSC Covered Services: those services which are required to be provided by the Contractor as specified in Appendix C to the MCO Contract.

Non-MCO SKSC Covered Services: those services which are coordinated by the Contractor, but are provided by EOHHS on a fee-for-service basis as specified in Appendix C to the MCO Contract).

Rating Category (RC) VI: the Rating Category to which SKSC Enrollees are assigned.

Reassessment: an ongoing evaluation process conducted by EOHHS to determine if a SKSC Enrollee continues to meet the medical criteria in **Exhibit A** to remain in the SKSC Program.

Reassessment Date: the date assigned by EOHHS identifying when to reevaluate a SKSC Enrollee's continued medical need for the SKSC Program.

Region: one of two EOHHS designated geographical regions of the state.

- **Western Region**: Springfield, Holyoke, and all the cities and towns west of the Springfield/Holyoke area as listed in **Exhibit B**.
- **Eastern Region**: All cities and towns east of the Springfield/Holyoke area as listed in **Exhibit B**.

Referral: a written request submitted to EOHHS, in a form and format determined by EOHHS, for the purpose of evaluating a child's medical needs and appropriateness for services through the SKSC Program.

SKSC Capitation Rate or RC VI Rate (or Capitation Rate, as appropriate depending on context): a per-SKSC Enrollee per month fee paid prospectively by EOHHS to the Contractor based on a defined set of MCO SKSC Covered Services. The Capitation Rate shall be comprised of a Medical Component and Administrative Component. See **Exhibit C**.

SKSC Case Review Team (CRT) Meeting: a monthly clinically-focused meeting comprised of EOHHS, DCF, and the Contractor to conduct case reviews of certain SKSC Enrollees for facilitation of ongoing care planning, collaboration, and problem-solving specific to a SKSC Enrollee.

SKSC Estimated Capitation Payment (ECP): a prospective monthly payment made by EOHHS to the Contractor based on the number of days in the month and an estimation of the number of member months multiplied by the applicable per Enrollee per month SKSC Capitation Rate.

SKSC Enrollee (or Enrollee, as appropriate depending on context): an individual who meets the criteria in **Exhibit A** and is an Enrollee in the SKSC Program enrolled in the Contractor's Plan under RC VI.

SKSC Enrollee's Family: as identified by DCF and as determined by the SKSC Enrollee's placement, certain individuals from the following placement options. For the purposes of this Contract, an SKSC Enrollee's Family may also include his or her biological family, if determined appropriate by DCF:

- **Adoptive Home**: an individual or family licensed by DCF to provide care for and adopt a Child in DCF custody.
- **Contracted Foster Home**: an individual or family licensed by a state-licensed placement agency to provide care for a child and who has provided, is providing, or will be providing such care to a Child in Care or Custody of DCF under a contract between the licensed placement agency and DCF.
- **Foster Home**: an individual or family licensed by DCF to provide care for a Child in Care or Custody of DCF.
- **Group Home**: a residence designed for latency-aged or adolescent children who have sufficiently internalized controls to be safe in a less staff intensive setting, and may progress to limited unsupervised time in the community. Children who cannot tolerate the intimacy of a family setting or who require a higher level of supervision and intensive clinical treatment than can reasonably be provided in a family setting may require placement in a Group Home program. Children with mental health disabilities, cognitive impairments, pervasive developmental disorders, complex medical problems, or who have significant sight or hearing impairments may also require placement in a Group Home program.
- **Guardian**: the individual, organization, or agency, which has been appointed guardian of the person by a court of the Commonwealth, in accordance with M.G.L. c. 201, or a court of competent jurisdiction in another state.
- **Medical Residence Foster Care**: A service model designed to provide care and treatment supports to children and youth who require intensive medical care management and coordination 24 hours a day, 365 days a year. This service model integrates a higher level of support and greater medically-focused support into the foster home.

SKSC Enrollee Days (or Enrollee Days, as appropriate depending on context): the sum of the number of days each SKSC Enrollee is enrolled in the SKSC Program under the Contractor's Plan.

SKSC High Cost Drugs: Unless otherwise specified by EOHHS, High Cost Drugs are drugs that have a typical treatment cost greater than $200,000 per patient per year, an FDA orphan designation, and treat an applicable condition that affects fewer than 20,000 individuals nationwide. See **Section 5.6.D** below.

Special Kids Special Care (SKSC) Program: a Complex Care Management program provided to certain medically-eligible Children in the Care or Custody of DCF, the enrollees of which meet the criteria in **Exhibit A** and are assigned to RC VI.

Urgent Medical Care Plan (UMCP): A document detailing specific interventions that should be initiated if a SKSC Enrollee has an Emergency Medical Condition or a need for Urgent Care.

SECTION 2. MCO CONTRACT

In addition to the obligations set forth in this **Attachment 1**, the Contractor shall comply with all applicable provisions of the MCO Contract when serving Enrollees in the SKSC Program.

Effective January 1, 2019, the directed payment specified in **Section 2.8.D.6** of the MCO Contract shall not apply when serving Enrollees in the SKSC Program.

SECTION 3. CONTRACTOR RESPONSIBILITIES

Section 3.1 SKSC Program Enrollment, Reassessment, and Transition

A. Enrollment in the SKSC Program

The Contractor shall notify Members and Enrollees in the SKSC Program, as directed by EOHHS, of a Member's or Enrollee's enrollment into the SKSC Program.

B. Reassessment

The Contractor shall assist EOHHS with the Reassessment process by providing EOHHS, 28 calendar days before a SKSC Enrollee's Reassessment Date, the following items:

1. The SKSC Enrollee's ICP, current through the date the Contractor submits it to EOHHS;
2. A completed Reassessment Summary Form, to be provided and amended from time to time by EOHHS; and
3. Additional documentation as requested by EOHHS.

C. Transition from the SKSC Program and Assignment to a Rating Category under the MCO Contract as Appropriate

The Contractor shall work with EOHHS, DCF, and other EOHHS- or DCF-identified stakeholders and interested parties to facilitate a smooth transition for SKSC Enrollees from the SKSC Program and the assignment of such Enrollees into a Rating Category under the MCO Contract, as appropriate, in accordance with this section.

1. The Contractor shall prepare a transition plan for the SKSC Enrollee that:
    a. Includes and documents a consultation with an SKSC Enrollee's Guardian(s) to listen and address any questions or concerns the SKSC Enrollee or his or her Guardian has about the transition;
    b. Documents aspects of the SKSC Enrollee's current ICP that the SKSC Enrollee or Guardian(s) consider essential to the well-being of the SKSC Enrollee;
2. The Contractor shall, prior to the SKSC Enrollee transitioning from the SKSC Program, direct the SKSC Enrollee and the SKSC Enrollee's Family to EOHHS or its designee for

further information about health plan options that the SKSC Enrollee will have after the SKSC transition.

3. The Contractor shall continue to meet its obligations with respect to MCO SKSC Covered Services, Non-MCO SKSC Covered Services, and Complex Care Management for each SKSC Enrollee through each SKSC Enrollee's Disenrollment Date; and

4. If the SKSC Enrollee, upon transition, remains in the Contractor's plan by being transitioned to be an Enrollee of the Contractor's under the MCO Contract, the Contractor shall comply with all continuity of care requirements in **Section 2.2** of the MCO Contract while accounting for the information in the transition plan developed in accordance with this section. This may include, among other things, allowing the Enrollee to continue to see certain providers or to continue working with certain of the Contractor's staff (such as the Complex Care Coordinator).

5. If the SKSC Enrollee, upon transition, enrolls with a different MassHealth-contracted managed care plan, the Contractor shall be available to assist, as appropriate, the SKSC Enrollee's new managed care plan comply with continuity of care requirements in **Section 2.2** of the MCO Contract.

Section 3.2 SKSC Enrollee Orientation, Materials, and Communications

The Contractor shall:

A. Within 2 business days of a SKSC Enrollee's Enrollment Date, unless otherwise approved by EOHHS, ensure that the SKSC Enrollee's Complex Care Management Coordinator schedules an initial home visit to meet with the SKSC Enrollee's Family. Such home visit shall:

   1. Occur prior to the SKSC Enrollee's Care Needs Screening required under the MCO Contract; and

   2. Be used to complete a thorough medical and psychosocial assessment of the SKSC Enrollee to assist the Complex Care Management Coordinator develop such SKSC Enrollee's ICP.

B. Provide new SKSC Enrollees with Enrollee Information tailored for SKSC Enrollees (e.g., how to access MCO SKSC Covered Services and Non-MCO SKSC Covered Services). Such Enrollee Information shall also include information about:

   1. Complex Care Management for SKSC Enrollees, including the role of the Complex Care Management Coordinator, DCF, and the SKSC Enrollee's Family; and

   2. Services provided by DCF that may benefit SKSC Enrollees and their families.

C. Prepare and distribute educational materials about the SKSC Program to SKSC Enrollees' Families, DCF, and other interested individuals as requested.

D. Tailor any materials, including its Enrollee handbook and Provider directory, for SKSC Enrollees and SKSC Enrollees' Families, as appropriate or as directed by EOHHS. All

materials intended for SKSC Enrollees or SKSC Enrollees' Families shall be subject to pre-approval by EOHHS at its discretion.

E. Modify or enhance its Member Services Department training in order to effectively educate these individuals about the SKSC Program so that they may appropriately serve SKSC Enrollees and SKSC Enrollees' Families. All such modifications and enhancements shall be subject to EOHHS review and approval at its discretion.

Section 3.3 Covered Services and Complex Care Management

A. Covered Services

The Contractor shall:

1. Authorize, arrange, coordinate, and provide to SKSC Enrollees, as of each SKSC Enrollee's Enrollment Date, all Medically Necessary MCO SKSC Covered Services listed in **Appendix C**, in accordance with the requirements in this Attachment 1 and the MCO Contract;
2. Coordinate the provision, as of each SKSC Enrollee's Enrollment Date, of all Non-MCO SKSC Covered Services listed in **Appendix C,** in accordance with the requirements in this Attachment 1 and the MCO Contract; and
3. Regularly evaluate, as it determines appropriate or as directed by EOHHS or DCF, the needs of SKSC Enrollees to ensure they are receiving appropriate services.

B. Complex Care Management

The Contractor shall:

1. Provide SKSC Enrollees with all components described in **Section 2.5** and **Section 2.6** of the MCO Contract as appropriate to address their Complex Care Management needs; provided, however, that the Contractor shall develop and maintain an Individualized Care Plan for each SKSC Enrollee which shall incorporate the MassHealth-required Care Needs Screening;
2. Regularly evaluate, as it determines appropriate or as directed by EOHHS or DCF, the needs of SKSC Enrollees to ensure their Complex Care Management needs are being addressed; and
3. Develop policies and procedures for care delivery, care coordination, and care management in a manner to effectively accommodate SKSC Enrollees and their relationship with DCF. Such policies and procedures shall be subject to EOHHS review and pre-approval and shall include components for;

    a. Communicating regularly with DCF to allow for DCF to better coordinate services that are not MCO SKSC Covered Services or services otherwise covered by MassHealth that it may provide to SKSC Enrollees and SKSC Enrollees' Families;

b. Providing original and updated copies of a SKSC Enrollee's ICP upon any changes to the ICP and at minimum on a quarterly basis, to such SKSC Enrollee's Family, DCF, other relevant providers involved with the SKSC Enrollee's care, and EOHHS;

c. Developing an Urgent Medical Care Plan (UMCP) consistent with DCF policies and procedures to address a SKSC Enrollee's unique care needs, and reviewing and modifying the UMCP as needed but at least annually;

1) The UMCP shall include interventions that should be initiated if such SKSC Enrollee has an Emergency Medical Condition or a need for Urgent Care.

2) The Contractor shall provide original and updated copies, if any, of a SKSC Enrollee's UMCP to DCF and such SKSC Enrollee's Family and PCP.

d. Providing an exclusive telephone number that SKSC Enrollees may call for after-hours, urgent care from an on-call clinician when their Complex Care Management Coordinators are unavailable. The Contractor shall ensure these on-call clinicians have access to the most recent versions of SKSC Enrollees' ICPs and UMCPs; and

e. Ensuring Discharge Planning, in accordance with the provisions set forth in the MCO Contract, is coordinated by the SKSC Enrollee's Complex Care Management Coordinator, and includes DCF, the SKSC Enrollee's Family and PCP, and the Contractor's clinical staff.

C. Complex Care Management Coordinator

The Contractor shall assign each SKSC Enrollee a Complex Care Management Coordinator, who shall coordinate and manage, for his or her assigned SKSC Enrollees, as described in this **Attachment 1**:

1. The provision of SKSC MCO Covered Services; and
2. Care delivery, care coordination, and care management to address the SKSC Enrollee's Complex Care Management needs.

Section 3.4 Management of the SKSC Program

The Contractor shall:

A. Maintain adequate staffing for the SKSC Program, including but not limited to an appropriate number of Complex Care Management Coordinators. The Contractor shall also identify key personnel responsible for managing the SKSC Program.

B. Provide regular training for personnel about the SKSC Program, the capacities necessary to serve SKSC Enrollees, and common issues and solutions related to the SKSC Program.

C. Develop and maintain policies and procedures addressing the following matters, all of which are subject to EOHHS review:

1. The determination of when it is appropriate to suggest to EOHHS that the SKSC Program is no longer suitable for an SKSC Enrollee;

2. The collaboration with other departments within the Contractor's organization and with other organizations and interested individuals, including Primary Care Providers, in supporting SKSC Enrollees' needs. These shall include strategies for collaborating with a SKSC Enrollee's school, for example, when a SKSC Enrollee has an Individualized Education Plan (IEP); and

3. The process for, and frequency of, evaluating a SKSC Enrollees' needs and ensuring they are receiving appropriate services and that their Complex Care Management needs are being addressed.

D. Manage Material Subcontractors, if any, in accordance with the MCO Contract. Any other matters related to Material Subcontractors or other subcontractors shall also be handled in accordance with the requirements set forth in the MCO Contract.

E. Provide EOHHS with data, information and reports regarding SKSC enrollment and SKSC Enrollees, as specified by EOHHS and in a form and format and at a frequency specified by EOHHS.

Section 3.5 Provider Network

The Contractor shall:

A. Maintain a Provider Network with capacities, expertise, and specialties sufficient to meet SKSC Enrollees' needs, as determined by EOHHS. With respect to such Provider Network, the Contractor shall meet all requirements set forth in the MCO Contract related to Providers and Network requirements;

B. Include as Providers in its Provider Network all network providers in its Provider Network under the MCO Contract;

C. Use best efforts to maintain continuity of care for new SKSC Enrollees by, in addition to satisfying the continuity of care requirements in the MCO Contract:

1. If the new SKSC Enrollee's PCP is part of the Provider Network, assisting the SKSC Enrollee, the SKSC Enrollee's Family, and DCF to:

a. Determine if the SKSC Enrollee's current PCP is appropriate given the SKSC Enrollee's needs; and

b. Select a new PCP within the Provider Network if the SKSC Enrollee, SKSC Enrollee's Family, and DCF wish to change PCPs.

2. If the new SKSC Enrollee's PCP is not part of the Provider Network:

a. Recruiting a new SKSC Enrollee's PCP, if not already a Network Provider, to join its Provider Network. ; and

b. If the Contractor and such PCP cannot agree on contractual terms for the PCP to be a part of the Provider Network or such PCP declines to join the Provider Network, assisting the SKSC Enrollee, SKSC Enrollee's Family, and DCF in selecting a new PCP within the Provider Network. The Contractor may enter into an out-of-network agreement with the SKSC Enrollee's current PCP, as appropriate, to ensure continuity of care until a new PCP within the Provider Network is selected.

D. Modify or enhance its Provider education in order to effectively inform these individuals about the SKSC Program so that they may appropriately serve SKSC Enrollees and SKSC Enrollees' Families. All such modifications and enhancements shall be subject to EOHHS review and pre-approval.

E. To ensure that SKSC Enrollees have access to PCPs with appropriate skills and experience with SKSC Enrollees and, as appropriate, with prior relationships with SKSC Enrollees, the Contractor may contract with such PCPs regardless of such PCPs' participation with other MassHealth managed care plans and EOHHS shall permit such PCPs to contract with the Contractor for this purpose.

Section 3.6 Reporting

The Contractor shall, at a frequency and in a form and format specified by EOHHS, report to EOHHS on utilization under this **Attachment 1** and on other matters as further directed by EOHHS.

Section 3.7 Contract Readiness

The Contractor shall, at the request of EOHHS:

A. Demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet all requirements in this Attachment 1 no later than 15 business days prior to the Contract Effective Date;

B. Provide to EOHHS or its designee, access to all facilities, sites, and locations at which one or more services or functions required under this Attachment 1 occurs or is provided;

C. Provide to EOHHS or its designee, access to all information, materials, or documentation pertaining to the provision of any service or function required under this Attachment 1 within five business days of receiving the request; and

D. Provide EOHHS with a Remedy Plan within five business days after being informed of any deficiency EOHHS identifies. EOHHS, may, in its discretion, modify or reject any such Remedy Plan, in whole or in part.

SECTION 4. EOHHS RESPONSIBILITIES

Section 4.1 SKSC Program Enrollment, Reassessment and Transition

A. Enrollment

EOHHS shall:

1. Determine whether the Member or Enrollee referred to EOHHS meets the requirements to participate in the SKSC Program as set forth in **Exhibit A** to this **Attachment 1**.

2. If EOHHS determines a Member is eligible to participate in the SKSC Program and such Member resides in a Region for which the Contractor is contracted to serve SKSC Enrollees, EOHHS shall enroll the Member in the Contractor's Plan as a SKSC Enrollee and therefore in RC VI for an initial period of no longer than two years.

B. Reassessment

EOHHS shall conduct and issue a decision with respect to Reassessments of each SKSC Enrollee on or before such SKSC Enrollee's Reassessment Date and shall notify the Contractor and DCF HMST of the result of each Reassessment on or before the date on which the SKSC Enrollee's initial enrollment in the SKSC Program is scheduled to end. At each Reassessment, EOHHS shall approve continued enrollment of a SKSC Enrollee for no longer than two years.

C. Transition from the SKSC Program and Assignment to a Rating Category under the MCO Contract as Appropriate

1. EOHHS shall disenroll a SKSC Enrollee from the SKSC Program, as appropriate if:

   a. A SKSC Enrollee no longer meets the criteria described in **Exhibit A** of the **Attachment 1**;

   b. A SKSC Enrollee is no longer a Child in the Care or Custody of DCF, and does not meet all of the following criteria:

      1) Such SKSC Enrollee remains classified by DCF as an "Open Case";

      2) Such SKSC Enrollee meets all criteria set forth in **Exhibit A** of the Contract; and

      3) Such SKSC Enrollee's legal guardian wants such SKSC Enrollee to remain enrolled in the SKSC Program.

   c. A SKSC Enrollee moves to a geographic area not located in the Contractor's Regions;

   d. A SKSC Enrollee reaches his or her twenty-second birthday; or

   e. A SKSC Enrollee loses MassHealth eligibility.

2. EOHHS shall ensure that each SKSC Enrollee's Transition Date is no longer than 30 calendar days from the date on which an event described above occurs, unless extenuating circumstances warrant extending this time period and the extension is agreed to by EOHHS and the Contractor.

3. Upon the SKSC Enrollee's disenrollment, the Contractor shall not be required to maintain a contract with the former SKSC Enrollee's PCP if that PCP is not otherwise a Provider in the Contractor's Provider Network under its MCO Contract or one if its Accountable Care Partnership Plan contract(s).

Section 4.2 EOHHS Liaison

EOHHS shall assign a designated staff member to be the EOHHS Liaison for the SKSC Program, who shall serve as the key contact person for this **Attachment 1** and shall assist with the overall management of the SKSC Program as EOHHS determines appropriate.

Section 4.3 Contract Readiness

In addition to the Contract Readiness requirements in the MCO Contract, EOHHS may, at its discretion, conduct a Readiness Review of each Contactor for this Attachment 1 that may include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of Members into the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS. EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under **Attachment 1**.

SECTION 5. PAYMENT AND FINANCIAL PROVISIONS

Section 5.1 Limited Incorporation of Section 4 of the MCO Contract

Section 4 of the MCO Contract shall apply to this **Attachment 1** as specified in this **Section 5**.

Section 5.2 Rating Category VI

Subject to all required federal approvals, EOHHS shall pay the Contractor, in accordance with **Section 5** of this **Attachment 1**, for providing MCO SKSC Covered Services to SKSC Enrollees (also referred to as Enrollees in RC VI). SKSC Enrollees are eligible for MCO SKSC and Non-MCO SKSC Covered Services as described in **Appendix C**.

Section 5.3 Payment Methodology

A. EOHHS shall make payment to the Contractor for MCO SKSC Covered Services provided under this **Attachment 1**, in accordance with the payment provisions in this **Section 5** and the SKSC Capitation Rates contained in **Exhibit C** to this **Attachment 1**.

B. SKSC Capitation Rates for Contract Year 2018

1. In Contract Year 2018, beginning on the Contract Operational Start Date, SKSC Capitation Rates for SKSC Enrollees shall be Actuarially Sound, in accordance with 42 CFR 438.4.

2. These SKSC Capitation Rates shall be Region-specific for each of the two Regions.

3. SKSC Capitation Rates shall be incorporated into **Exhibit C** to this **Attachment 1** and shall be comprised of the Medical Component of the SKSC Capitation Rate and the Administrative Component of the SKSC Capitation Rate. The Administrative Component of the SKSC Capitation Rate shall reflect the cost of administering medical benefits, underwriting gain, care management, and any other non-medical costs.

C. SKSC Capitation Rates for Subsequent Contract Years

1. After the first Contract Year, EOHHS shall annually develop the SKSC Capitation Rate in each Region, or statewide, as determined appropriate by EOHHS. EOHHS intends that the SKSC Capitation Rate shall be consistent for all MCOs contracted to provide services under the SKSC Program. However, EOHHS may provide a different SKSC Capitation Rate to an MCO, in EOHHS' discretion, to account for other unique circumstances.

2. EOHHS shall meet with the Contractor annually, upon request, to explain the SKSC Capitation Rates.

3. Prior to the beginning of the Contract Year, EOHHS shall incorporate, by amendment, the SKSC Capitation Rates by Region into **Exhibit C** of this **Attachment 1**; provided, however, that EOHHS may amend the SKSC Capitation Rates at such other times as may be necessary as determined by EOHHS, or as a result of changes in federal or state law, including but not limited to, to account for changes in eligibility, covered services, or copayments.

D. Failure to Accept Base Capitation Rates

1. In the event that the Contractor does not accept the SKSC Capitation Rates for the new Contract Year at a minimum of 21 days prior to the first day of the new Contract Year, EOHHS will continue to pay the Contractor the current year's SKSC Capitation Rates and the Contractor shall accept such payment as payment in full under the Contract subject to paragraphs a. and b. below. EOHHS may also halt enrollment into the SKSC Program and therefore halt all new SKSC Enrollee assignments to the Contractor's Plan until the Contractor accepts the SKSC Capitation Rates offered by EOHHS.

   a. In the event that the prior year's SKSC Capitation Rates are higher than SKSC Capitation Rates for the new Contract Year that the Contractor ultimately accepts, EOHHS may recoup the higher Capitation Payments made during the interim rate period.

   b. In the event that the prior year's SKSC Capitation Rates are lower than the SKSC Capitation Rates for the new Contract Year and the Contractor does not accept the SKSC Capitation Rates offered by EOHHS by the beginning of the new Contract Year, EOHHS will not retroactively adjust the SKSC Capitation Rates for the interim rate period.

   c. In the event that the Contractor does not accept the SKSC Capitation Rates for the new Contract Year within sixty (60) days following the end of the prior Contract

Year, EOHHS or Contractor may amend the MCO Contract to remove this **Attachment 1** and all other obligations for the Contactor to serve SKSC Enrollees.

2. If the Contractor does not accept the SKSC Capitation Rates, EOHHS or Contractor may amend the MCO Contract to remove this **Attachment 1** and all other obligations for the Contactor to serve SKSC Enrollees. In such a case, the Contractor shall be obligated to continue to provide services under this **Attachment 1** to SKSC Enrollees until such time as all SKSC Enrollees are disenrolled from the Contractor's Plan in accordance with **Section 5.6.H** of the MCO Contract. The Contractor shall accept the SKSC Capitation Rates in accordance with **Section 5.3.E** above, adjusted by EOHHS as it determines necessary to account for changes in eligibility, services under this **Attachment 1** or cost sharing, as payment in full for services delivered to SKSC Enrollees under this **Attachment 1** during such time.

E. Estimated Capitation Payment Process

1. EOHHS shall make Capitation Payments for Enrollees in each Rating Category (RC) VI Region as follows:

   a. For each RC VI Region, EOHHS shall calculate an estimated full month Capitation Payment on or about the third Friday of the month preceding the Payment Month based on estimated enrollment data for the Payment Month.

   b. For Enrollees for whom EOHHS has assigned a specific disenrollment date due to a qualifying event within the Payment Month, EOHHS shall make a prorated Estimated Capitation Payment to the Contractor. The prorated Estimated Capitation Payment will equal:

      1) the monthly Capitation Rate multiplied by,

      2) the number of days in the Payment Month that the member is enrolled up to and including the disenrollment date of the qualifying event divide by,

      3) the total number of days in the Payment Month.

2. The Contractor shall be responsible for providing MCO SKSC Covered Services to such SKSC Enrollees as of the Effective Day of Enrollment in accordance with **Section 3.3** of this **Attachment 1**.

F. Non-Medical Programs and Services

Section 4.2.H of the MCO Contract is hereby incorporated by reference.

G. Indian Enrollees and Indian Health Care Providers

Section 4.2.I of the MCO Contract is hereby incorporated by reference. "MCO Covered Services" shall be read as meaning "MCO SKSC Covered Services".

H. Suspension of Payments

Section 4.2.J of the MCO Contract is hereby incorporated by reference.

I. Non-Payment and Reporting of Provider Preventable Conditions

Section 4.2.K of the MCO Contract is hereby incorporated by reference.

Section 5.4 Adjustments or Additions to Payments

A. Health Insurer Provider Fee Adjustment

In accordance with CMS guidance, to account for the portion of the Contractor's Health Insurer Provider Fee under Section 9010 of the ACA (the HIPF) that is allocable to MassHealth premiums, if the Contractor is subject to such HIPF:

1. Each year, the Contractor shall provide EOHHS with information about the Contractor's HIPF, as requested by EOHHS, including but not limited to the bill the Contractor receives from the U.S. Internal Revenue Service.
2. EOHHS shall calculate and perform an adjustment set forth in **Exhibit C** to this **Attachment 1** to the Contractor's SKSC Capitation Rates to account for the portion of the Contractor's HIPF that is allocable to MassHealth premiums and, subject to federal financial participation, for the tax liability related to the HIPF, if applicable.
3. If allowed by CMS for a given Calendar Year, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after October 1 of the following Calendar Year.

Section 5.5 Payment Reconciliation Process

A. Enrollment-related Reconciliations

1. EOHHS shall perform the following monthly reconciliations with a lookback period determined by EOHHS and adjust Estimated Capitation Payments as below:

    a. Enrollees Who Change Rating Categories during the Payment Months included in the Lookback Period

    EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total Estimated Capitation Payment issued to the Contractor for Enrollees who change Rating Categories during any of the Payment Months in the lookback period, and issue a pro-rated monthly capitation payment that reflects the actual number of Enrollee Days in any of the months in the lookback period for each of the affected Rating Categories.

b. Enrollees Who Disenroll During the Payment Month

EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total Estimated Capitation Payment issued to the Contractor for Enrollees who disenroll from the Contractor's Plan during the any of the Payment Months in the lookback period and issue a pro-rated monthly capitation payment to reflect the actual number of Enrollee Days in any of the months in the lookback period.

c. Members Who Enroll in the SKSC Program During a Payment Month

For Members who enroll in the Contractor's Plan during the Payment Months in the lookback period but after the Estimated Capitation Payment has been issued to the Contractor for any of such Payment Months in the lookback period, EOHHS shall, in the month following the Payment Month, issue a pro-rated monthly capitation payment to reflect the actual number of Enrollee Days with respect to such Members for any of the Payment Months in the lookback period.

2. EOHHS shall perform an annual reconciliation of the Estimated Capitation Payments to adjust for any enrollment discrepancies not included in the monthly reconciliations with the lookback period determined by EOHHS;

3. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies pursuant to the reconciliations in this section. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of the EOHHS, through recoupment from future capitation and/or reconciliation payments as described in **Section 4** of the MCO Contract.

a. Overpayments - Overpayments shall constitute the amount actually paid to the Contractor for all Rating Category VI in excess of the amount that should have been paid in accordance with EOHHS's reconciliation.

b. Underpayments – Underpayments shall constitute the amount not paid to the Contractor for Rating Category VI that should have been paid in accordance with EOHHS's reconciliation.

B. EOHHS shall perform a Continuing Services Reconciliation in accordance with **Section 4.4.C** of the MCO Contract.

Section 5.6 Risk Sharing for the SKSC Program

A. General Requirement

The Contractor shall participate in any risk-sharing arrangement as directed by EOHHS in each Contract Year.

B. General Provisions

1. The General Provisions in **Section 4.5.B** of the MCO Contract shall apply to risk sharing arrangements in this **Section 5.6** of this **Attachment 1**.

2. Notwithstanding anything to the contrary in this **Attachment 1** or otherwise in the MCO Contract (including any Appendices and amendments thereto), EOHHS will not reprice the Contractor's paid Claims for the purposes of calculating the risk sharing payments set forth in this **Attachment 1**.

C. Attachment 1 Overall Risk Sharing Arrangement

For all Regions, the Contractor and EOHHS shall share risk for the Medical Component of the SKSC Capitation Rate in accordance with the following provisions.

1. Overall Approach

All payments shall be calculated and determined by EOHHS based on the Contractor's actual medical expenditures relating to SKSC Enrollees, and the Medical Component of the SKSC Capitation Rate aggregated across all Regions.

2. Medical Component of the SKSC Capitation Rate Payment

EOHHS shall first determine the Medical Component of the SKSC Capitation Rate Payment for the applicable Contract Year in aggregate across all Regions. The Contractor's Medical Component of the SKSC Capitation Rate Payment for the Contract Year shall mean the sum of the Monthly SKSC Capitation Payments actually paid by the EOHHS for each month of the Contract Year for each Region, as determined by EOHHS, less the Administrative Component of such payment utilizing the amount set forth in **Appendix D** to the MCO Contract, per member per month, and less the SKSC Pharmacy – Other High Cost Drug Category of Service related to the SKSC Capitation Payment as set forth in **Section 5.6.D** below:

3. Actual Medical Expenditures

EOHHS shall then determine the Contractor's actual medical expenditures in aggregate across all Regions related to the provision of SKSC MCO Covered Services in **Appendix C** of the MCO Contract for the applicable Contract Year based on the data submitted by the Contractor in accordance with **Section 5.6.B.1** above, and may verify such data in a manner it determines appropriate.

a. Expenditures shall exclude any and all case management and administrative costs. Actual medical expenditures shall exclude actual SKSC High-Cost drug expenditures relating to all SKSC Enrollees. See **Section 5.6.B.1** above.

b. For the report required pursuant to **Section 5.6.B.1** of this **Attachment 1**(and, as a result, **Section 4.5.B** of the MCO Contract), the Contractor shall include 6 months of Claims run-out, including the best estimate of any Claims incurred but not reported (IBNR) for Claims run-out of seven months or greater and any applicable IBNR

completion factor. In the event that the above final statement of medical expenditures includes an incurred but not reported (IBNR) completion factor greater than 1% for total medical costs, EOHHS reserves the right to conduct an audit of the Contractor's IBNR methodology.

4. If the Contractor's actual Medical Expenditures, as determined by EOHHS in accordance with the above provisions, in the aggregate is greater than or less than the Medical Component of the Capitation Rate Payment for the Contract Year in aggregate, the Contractor and EOHHS shall share the resulting loss or gain, respectively, in accordance with the corridors set forth in **Exhibit C** to this **Attachment 1**.

5. EOHHS shall exclude from all calculations related to this risk sharing arrangement the Contractor's reinsurance premiums paid and recovery revenues received if the Contractor chooses to purchase reinsurance

D. SKSC High Cost Drug Risk Sharing Arrangement

For all Regions, the Contractor and EOHHS shall share risk for the cost of providing SKSC High Cost Drugs in accordance with the following provisions. SKSC High Cost Drugs shall be as defined in **Section 1** of this **Attachment 1**.

1. Overall Approach

   All payments shall be calculated and determined by EOHHS based on the Contractor's:

   a. Actual SKSC High-Cost Drug expenditures relating to all SKSC Enrollees, and

   b. The amount of the Capitation Rate Payment attributed to the SKSC Pharmacy – Other High Cost Drug Category of Service set forth in **Exhibit C** of this **Attachment 1** aggregated across all Regions. The SKSC Pharmacy – Other High Cost Drug Category of Service set forth in **Exhibit C** of this **Attachment 1** shall be from the Special Kids Special Care Capitation Rate Calculation Sheet (CRCS) and EOHHS shall provide the Contractor with such CRCS.

2. EOHHS will first determine the amount paid to the Contractor by EOHHS for SKSC High Cost Drugs for the Contract Year by multiplying the following:

   a. The SKSC Pharmacy – Other High-Cost Drug Category of Service, which shall be determined by EOHHS and provided to the Contactor in **Exhibit C** to this **Attachment 1**; by

   b. The number of Member months determined by EOHHS.

3. EOHHS shall then determine the Contractor's actual expenditures for SKSC High Cost Drugs in aggregate across all Regions for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 5.6.B.1** above, and may verify such data in a manner it determines appropriate.

4. If the Contractor's actual Medical Expenditures for SKSC High Cost Drugs, as determined by EOHHS in accordance with the above provisions, in the aggregate is greater than or less than the amount paid by EOHHS to the Contractor for the provision of SKSC High Cost Drugs for the Contract Year in aggregate, the Contractor and EOHHS shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Exhibit C** of this **Attachment 1**.

Section 5.7 Performance Incentive Arrangements

A. The General Provisions in Section 4.6 of the MCO Contract shall apply to performance incentive arrangements in this Section 5.7 of this Attachment 1.

B. Quality Incentive Arrangement

1. The Provisions in Section 4.6.B of the MCO Contract shall apply to the SKSC enrollees

C. Quality and Equity Incentive Program

1. The Provisions in Section 4.6.C of the MCO Contract shall apply to the SKSC enrollees

SECTION 6. ADDITIONAL TERMS AND CONDITIONS

The Additional Terms and Conditions set forth in **Section 5** of the MCO Contract are incorporated by reference, except as modified below.

Section 6.1 Attachment 1 Term

This Contract shall be in effect upon execution and end on December 31, 2027, subject to (1) the Contractor's acceptance of SKSC Capitation Rates as determined by EOHHS under this Contract; (2) the Contractor's satisfactory performance, as determined by EOHHS, of all duties and obligations under this Contract; and (3) the provisions of **Section 5.6** of the MCO Contract; provided, however that EOHHS may extend the Contract in any increments for up to three (3) additional years at the sole discretion of EOHHS, upon terms agreed upon by the parties. EOHHS reserves the right to further extend the Contract for any reasonable increment it determines necessary to complete a subsequent procurement. Extension of the Contract resulting from this RFR is subject to further legislative appropriations, continued legislative authorization, and EOHHS' determination of satisfactory performance.

Section 6.2 Termination of Attachment 1 and Continued Obligations of the Parties

In addition to the terms set forth herein, both parties shall have the rights and obligations set forth in **Section 5.6** of the MCO Contract with respect to termination of and continued obligations under this **Attachment 1**. In addition, EOHHS may terminate this **Attachment 1** if it decides to discontinue the SKSC Program or upon termination or expiration of the MCO Contract.

Section 6.3 Key Personnel

The individuals identified pursuant to **Section 5.3.B**. of the RFR, in addition to other individuals identified by EOHHS as important to the Contractor's management of the SKSC Program, are key personnel. **Section 2.3.A**. of the MCO Contract shall apply with respect to these key personnel.

Section 6.4 Conflict of Interest

In addition to the obligations set forth in **Section 5.3.O** of the MCO Contract, the Contractor shall complete and submit a disclosure form provided by EOHHS in accordance with the time period specified by EOHHS. The Contractor shall complete and submit such disclosure form upon EOHHS request and upon a change to any information the Contractor provides to EOHHS in a submission of such form.

EXHIBIT A to ATTACHMENT 1

Criteria to Participate in the

Special Kids Special Care (SKSC) Program

Members and Enrollees may participate in the SKSC Program in the Contractor's Plan under RC VI if a review by EOHHS of application materials and medical documentation shows that the Member satisfies the following criteria:

A. General Criteria

To participate in the SKSC Program, a Member or Enrollee must:

1. Be a Child in the Care or Custody of DCF;
2. Reside in a Foster Home or other group setting described in **Section 1** of the Contract under "SKSC Enrollee's Family"; provided, however, that a Member is not eligible for enrollment in the SKSC Program if residing in an Adoptive Home or Guardianship Home at the time of such Member's Referral. A Member may reside in an Adoptive Home or Guardianship Home only once the Member is enrolled in the SKSC Program;
3. Be no more than twenty-two years of age;
4. Have MassHealth as the sole payer of health insurance, have MassHealth Standard as a benefit plan, and otherwise be eligible for enrollment in a MassHealth MCO; and
5. Meet the medical criteria listed in **Section B**, below.

B. Medical Criteria

To participate in the SKSC Program:

1. A Member must be determined by EOHHS to need:
    a. Complex medical management on a regular basis over a prolonged period of time; and
    b. Either one of the following:
        1) Direct administration of skilled nursing care on a regular basis over a prolonged period of time, requiring complex nursing procedures; or
        2) Skilled assessment or monitoring on a regular basis over a prolonged period of time related to an unstable medical condition.

2. A Member's medical documentation must demonstrate that:

    a. The Member requires complex medical management by a physician or under the supervision of a physician on a regular basis over a prolonged period of time; and

    b. Either of the following in B.2.b.1) and B.2.b.2) below:

        1) The Member requires direct administration of skilled nursing care on a regular basis over a prolonged period of time, requiring complex nursing procedures which may include the need for:

            a) intermittent bladder catheterization;

            b) jejunostomy (J) tube, nasojejunal (N/J) tube, nasogastric (N/G) tube, orogastric (O/G) tube, gastrostomy (G) tube feedings;

            c) ostomy care – ileostomy, colostomy;

            d) intravenous administration of nutrition or medication;

            e) care of indwelling catheters;

            f) monitoring or changing tracheotomy tube;

            g) ventilator care;

            h) deep suctioning; or

            i) other specific nursing care.

        2) The Member requires skilled assessment or monitoring on a regular basis over a prolonged period of time related to an unstable medical condition which may include the need for:

            a) respiratory status (e.g., severe asthma, or tracheomalacia, severe cystic fibrosis, high risk of aspiration);

            b) cardiac status (e.g., unstable congenital heart disease, arrhythmia, congestive heart failure);

            c) metabolic status (e.g., brittle diabetes mellitus, severe metabolic disease such as propionic acidemia);

            d) growth and nutrition (e.g., severe failure to thrive, biliary atresia, end-stage liver disease);

            e) neurological status (e.g., uncontrolled seizures);

f) oncologic-hematologic status (e.g., active cancer, aplastic anemia, severe sickle cell anemia);

g) immunologic status (e.g., full-blown AIDS, severe immunodeficiency such as severe combined immunodeficiency syndrome (SCIDS));

h) renal-genitourinary status (e.g., severe renal failure);

i) allergic or skin or autoimmune diseases (e.g., severe allergies, ectodermal dysplasia, dermatomyositis);

j) post-organ transplant;

k) multisystem disease (e.g., multiple diagnoses which together create a state of medical fragility); or

l) other assessment or monitoring (specify related diagnosis).

EXHIBIT B TO ATTACHMENT 1

Cities and Towns in Each Region

Region	Official City or Town	USPS Place Name (if used)
Eastern	Abington	Abington
	Acton	Acton
	Acushnet	Acushnet
	Amesbury	Amesbury
	Andover	Andover
	Aquinnah	Aquinnah
	Arlington	Arlington
	Ashburnham	Ashburnham
	Ashby	Ashby
	Ashland	Ashland
	Athol	Athol
	Attleboro	Attleboro
	Auburn	Auburn
	Avon	Avon
	Ayer	Ayer
	Barnstable	Barnstable
		Centerville
	Barre	Barre
	Bedford	Bedford
	Bellingham	Bellingham
	Belmont	Belmont
	Berkley	Berkley
	Berlin	Berlin
	Beverly	Beverly
	Billerica	Billerica
	Blackstone	Blackstone
	Bolton	Bolton

Region	Official City or Town	USPS Place Name (if used)
	Boston	Allston
		Boston
		Brighton
		Charlestown
		Dorchester
		East Boston
		Hyde Park
		Jamaica Plain
		Mattapan
		Readville
		Roslindale
		Roxbury
		West Roxbury
	Bourne	Bourne
		Monument Beach
	Boxborough	Boxborough
	Boxford	Boxford
	Boylston	Boylston
	Braintree	Braintree
	Brewster	Brewster
	Bridgewater	Bridgewater
	Brimfield	Brimfield
	Brockton	Brockton
	Brookfield	Brookfield
	Brookline	Brookline
	Burlington	Burlington
	Cambridge	Cambridge
	Canton	Canton
	Carlisle	Carlisle
	Carver	Carver
	Charlton	Charlton

Region	Official City or Town	USPS Place Name (if used)
	Chatham	Chatham
	Chelmsford	Chelmsford
	Chelsea	Chelsea
	Chilmark	Chilmark
	Clinton	Clinton
	Cohasset	Cohasset
	Concord	Concord
	Danvers	Danvers
	Dartmouth	Dartmouth
	Dedham	Dedham
	Dennis	Dennis
	Dighton	Dighton
	Douglas	Douglas
	Dover	Dover
	Dracut	Dracut
	Dudley	Dudley
	Dunstable	Dunstable
	Duxbury	Duxbury
	East Bridgewater	East Bridgewater
	East Brookfield	East Brookfield
	Eastham	Eastham
	Easton	Easton
	Edgartown	Edgartown
	Essex	Essex
	Everett	Everett
	Fairhaven	Fairhaven
	Fall River	Fall River
	Falmouth	Falmouth
	Fitchburg	Fitchburg
	Foxborough	Foxborough
	Framingham	Framingham

Region	Official City or Town	USPS Place Name (if used)
	Franklin	Franklin
	Freetown	Freetown
	Gardner	Gardner
	Georgetown	Georgetown
	Gloucester	Gloucester
	Gosnold	Gosnold
	Grafton	Grafton
		North Grafton
	Groton	Groton
	Groveland	Groveland
	Halifax	Halifax
	Hamilton	Hamilton
	Hanover	Hanover
	Hanson	Hanson
	Hanson/Pembroke	Bryantville
	Hardwick	Hardwick
	Harvard	Harvard
	Harwich	Harwich
	Haverhill	Haverhill
	Hingham	Hingham
	Holbrook	Holbrook
	Holden	Holden
	Holland	Holland
	Holliston	Holliston
	Hopedale	Hopedale
	Hopkinton	Hopkinton
	Hubbardston	Hubbardston
	Hudson	Hudson
	Hull	Hull
	Ipswich	Ipswich
	Kingston	Kingston

Region	Official City or Town	USPS Place Name (if used)
	Lakeville	Lakeville
	Lancaster	Lancaster
	Lawrence	Lawrence
	Leicester	Leicester
	Leominster	Leominster
	Lexington	Lexington
	Lincoln	Lincoln
	Littleton	Littleton
	Lowell	Lowell
	Lunenburg	Lunenburg
	Lynn	Lynn
	Lynnfield	Lynnfield
	Malden	Malden
	Manchester-By-The-Sea	Manchester-by-the-Sea
	Mansfield	Mansfield
	Marblehead	Marblehead
	Marion	Marion
	Marlborough	Marlborough
	Marshfield	Marshfield
		Marshfield Hills
	Mashpee	Mashpee
	Mattapoisett	Mattapoisett
	Maynard	Maynard
	Medfield	Medfield
	Medford	Medford
		West Medford
	Medway	Medway
	Melrose	Melrose
	Mendon	Mendon
	Merrimac	Merrimac
	Methuen	Methuen

Region	Official City or Town	USPS Place Name (if used)
	Middleborough	Middleborough
	Middleton	Middleton
	Milford	Milford
	Millbury	Millbury
		West Millbury
	Millis	Millis
	Millville	Millville
	Milton	Milton
	Nahant	Nahant
	Nantucket	Nantucket
	Natick	Natick
	Needham	Needham
	New Bedford	New Bedford
	New Braintree	New Braintree
	New Salem	New Salem
	Newbury	Newbury
	Newburyport	Newburyport
	Newton	Newton
	Norfolk	Norfolk
	North Andover	North Andover
	North Attleborough	North Attleboro
	North Brookfield	North Brookfield
	North Reading	North Reading
	Northborough	Northborough
	Northbridge	Northbridge
	Norton	Norton
	Norwell	Norwell
	Norwood	Norwood
	Oak Bluffs	Oak Bluffs
	Oakham	Oakham
	Orange	Orange

Region	Official City or Town	USPS Place Name (if used)
	Orleans	Orleans
	Oxford	North Oxford
		Oxford
	Paxton	Paxton
	Peabody	Peabody
	Pembroke	Pembroke
	Pepperell	Pepperell
	Petersham	Petersham
	Phillipston	Phillipston
	Plainville	Plainville
	Plymouth	Plymouth
	Plympton	Plympton
	Princeton	Princeton
	Provincetown	Provincetown
	Quincy	Quincy
	Randolph	Randolph
	Raynham	Raynham
	Reading	Reading
	Rehoboth	Rehoboth
	Revere	Revere
	Rochester	Rochester
	Rockland	Rockland
	Rockport	Rockport
	Rowley	Rowley
	Royalston	Royalston
	Rutland	Rutland
	Salem	Salem
	Salisbury	Salisbury
	Sandwich	Sandwich
	Saugus	Saugus
	Scituate	Scituate

Region	Official City or Town	USPS Place Name (if used)
	Scituate	Humarock
	Seekonk	Seekonk
	Sharon	Sharon
	Sherborn	Sherborn
	Shirley	Shirley
	Shrewsbury	Shrewsbury
	Somerset	Somerset
	Somerville	Somerville
	Southborough	Southborough
	Southbridge	Southbridge
	Spencer	Spencer
	Sterling	Sterling
	Stoneham	Stoneham
	Stoughton	Stoughton
	Stow	Stow
	Sturbridge	Sturbridge
	Sudbury	Sudbury
	Sutton	Sutton
	Swampscott	Swampscott
	Swansea	Swansea
	Taunton	Taunton
	Templeton	Templeton
	Tewksbury	Tewksbury
	Tisbury	Tisbury
	Topsfield	Topsfield
	Townsend	Townsend
	Truro	Truro
	Tyngsborough	Tyngsborough
	Upton	Upton
	Uxbridge	Uxbridge
	Wakefield	Wakefield

Region	Official City or Town	USPS Place Name (if used)
	Wales	Wales
	Walpole	Walpole
	Waltham	Waltham
	Wareham	Wareham
	Warren	Warren
	Warwick	Warwick
	Watertown	Watertown
	Wayland	Wayland
	Webster	Webster
	Wellesley	Babson Park
		Wellesley
	Wellfleet	Wellfleet
	Wenham	Wenham
	West Boylston	Oakdale
		West Boylston
	West Bridgewater	West Bridgewater
	West Brookfield	West Brookfield
	West Newbury	West Newbury
	West Tisbury	West Tisbury
	Westborough	Westborough
	Westford	Westford
	Westminster	Westminster
	Weston	Weston
	Westport	Westport
	Westwood	Westwood
	Weymouth	Weymouth
	Whitman	Whitman
	Wilmington	Wilmington
	Winchendon	Winchendon
	Winchester	Winchester
	Winthrop	Winthrop

Region	Official City or Town	USPS Place Name (if used)
	Woburn	Woburn
	Worcester	Worcester
	Wrentham	Sheldonville
		Wrentham
Western	Adams	Adams
	Agawam	Agawam
	Alford	Alford
	Amherst	Amherst
	Ashfield	Ashfield
	Becket	Becket
	Belchertown	Belchertown
	Bernardston	Bernardston
	Blandford	Blandford
	Buckland	Buckland
	Charlemont	Charlemont
	Cheshire	Cheshire
	Chester	Chester
	Chesterfield	Chesterfield
	Chicopee	Chicopee
	Clarksburg	Clarksburg
	Colrain	Colrain
	Conway	Conway
	Cummington	Cummington
	Dalton	Dalton
	Deerfield	Deerfield
	East Longmeadow	East Longmeadow
	Easthampton	Easthampton
	Egremont	Egremont
	Erving	Erving
	Florida	Florida
	Gill	Gill

Region	Official City or Town	USPS Place Name (if used)
	Goshen	Goshen
	Granby	Granby
	Granville	Granville
	Great Barrington	Great Barrington
		Housatonic
	Greenfield	Greenfield
	Hadley	Hadley
	Hampden	Hampden
	Hancock	Hancock
	Hatfield	Hatfield
	Hawley	Hawley
	Heath	Heath
	Hinsdale	Hinsdale
	Holyoke	Holyoke
	Huntington	Huntington
	Lanesborough	Lanesborough
	Lee	Lee
	Lenox	Lenox
	Leverett	Leverett
	Leyden	Leyden
	Longmeadow	Longmeadow
	Ludlow	Ludlow
	Middlefield	Middlefield
	Monroe	Monroe
	Monson	Monson
	Montague	Montague
	Monterey	Monterey
	Montgomery	Montgomery
	Mount Washington	Mount Washington
	New Ashford	New Ashford
	New Marlborough	New Marlborough

Region	Official City or Town	USPS Place Name (if used)
	North Adams	North Adams
	Northampton	Northampton
	Northfield	Northfield
	Otis	Otis
	Palmer	Palmer
	Pelham	Pelham
	Peru	Peru
	Pittsfield	Pittsfield
	Plainfield	Plainfield
	Richmond	Richmond
	Rowe	Rowe
	Russell	Russell
	Sandisfield	Sandisfield
	Savoy	Savoy
	Sheffield	Sheffield
	Shelburne	Shelburne
	Shutesbury	Shutesbury
	South Hadley	South Hadley
	Southampton	Southampton
	Southwick	Southwick
	Springfield	Springfield
	Stockbridge	Stockbridge
	Sunderland	Sunderland
	Tolland	Tolland
	Tyringham	Tyringham
	Ware	Ware
	Wendell	Wendell
	West Springfield	West Springfield
	West Stockbridge	West Stockbridge
	Westfield	Westfield
	Whately	Whately

Region	Official City or Town	USPS Place Name (if used)
	Wilbraham	Wilbraham
	Williamsburg	Williamsburg
	Williamstown	Williamstown
	Windsor	Windsor
	Worthington	Worthington

EXHIBIT C TO ATTACHMENT 1

SKSC CAPITATION RATES AND RISK SHARING ARRANGEMENT INFORMATION

RATE YEAR 2023

Listed below are the Per Member Per Month (PMPM) SKSC Capitation Rates for Rate Year 2023 (April 1, 2023, through December 31, 2023), subject to state appropriation and all necessary federal approvals. For Rate Year 2023, EOHHS has determined that a statewide rate is appropriate; therefore, the rates for the Eastern and Western Regions are the same.

SKSC Capitation Rates / RC VI Rates		
April 1, 2023 – December 31, 2023		
MEDICAL COMPONENT	ADMINISTRATIVE COMPONENT	TOTAL BASE CAPITATION RATE
(per member per month)	(per member per month)	(per member per month)
$16,634.73	$1,078.71	$17,713.44

SKSC RISK SHARING ARRANGEMENTS

Attachment 1 Overall Risk Sharing Arrangement (Section 5.6.C)

The amount of the Gain on the Medical Component of the Capitation Rate Payment for the Contract Year shall be defined as the difference between the Medical Component of the Capitation Rate Payment for the Contract Year and the Contractor's actual medical expenditures for SKSC MCO Covered Services for the Contract Year, if such actual expenditures are less than the Medical Component of the Capitation Rate Payment for the Contract Year. The Gain shall be calculated in aggregate across all Regions.

The amount of the Loss on the Medical Component of the Capitation Rate Payment for the Contract Year shall be defined as the difference between the Medical Component of the Capitation Rate Payment for the Contract Year and the Contractor's actual medical expenditures for SKSC MCO Covered Services for the Contract Year, if such actual expenditures are greater than the Medical Component of the Capitation Rate Payment for the Contract Year. The Loss shall be calculated in aggregate across all Regions.

	EOHHS Share of Gain or Loss	Contractor's Share of Gain or Loss
Portion of Gain or Loss less than or equal to $100,000	90%	10%
Portion of Gain or Loss greater than $100,000	100%	0%

SKSC High Cost Drug Risk Sharing Arrangement (Section 5.6.D)

The amount of the Gain on the SKSC Pharmacy – Other High Cost Drug Category of Service of the Capitation Rate Payment for the Contract Year shall be defined as the difference between the SKSC High-Cost Drug Category of Service of the Capitation Rate Payment for the Contract Year and the Contractor's actual medical expenditures for SKSC High-Cost Drugs for the Contract Year, if such actual expenditures are less than the SKSC High-Cost Drug Category of Service of the Capitation Rate Payment for the Contract Year. The Gain shall be calculated in aggregate across all Regions.

The amount of the Loss on the SKSC Pharmacy – Other High Cost Drug Category of Service of the Capitation Rate Payment for the Contract Year shall be defined as the difference between the SKSC High-Cost Drug Category of Service of the Capitation Rate Payment for the Contract Year and the Contractor's actual medical expenditures for SKSC High-Cost Drugs for the Contract Year, if such actual expenditures are greater than the SKSC High-Cost Drug Category of Service of the Capitation Rate Payment for the Contract Year. The Loss shall be calculated in aggregate across all Regions.

	EOHHS Share of Gain or Loss	Contractor's Share of Gain or Loss
Portion of Gain or Loss less than or equal to $100,000	99%	1%
Portion of Gain or Loss greater than $100,000	100%	0%

Listed below is the SKSC Pharmacy – Other High-Cost Drug Category of Service used for the Risk Sharing Arrangement set forth in **Section 5.6.D** above, on a per member per month (PMPM) basis for Rate Year 2023 (April 1, 2023, through December 31, 2023). This Category of Service represents a portion of the Medical Component of the SKSC Capitation Rate.

Effective April 1, 2023 – December 31, 2023
SKSC Pharmacy – Other High-Cost Drug Category of Service **(per member per month)** $3,130.41

EXHIBIT D TO ATTACHMENT 1

SKSC CAPITATION RATES AND RISK SHARING ARRANGEMENT INFORMATION FOR CONTRACT YEAR 2020

Contract Year 3 (2020)

Listed below are the Per Member Per Month (PMPM) SKSC Capitation Rates for Contract Year 2020 (January 1, 2020, through December 31, 2020) (also referred to as the Rate Year 2020), subject to state appropriation and all necessary federal approvals. For Contract Year 2020, EOHHS has determined that a statewide rate is appropriate; therefore, the rates for the Eastern and Western Regions in the table below are the same.

SKSC Capitation Rates / RC VI Rates			
January 1, 2020 - March 31, 2020			
REGION	MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Eastern	$10,841.39	$924.30	$11,765.69
Western	$10,841.39	$924.30	$11,765.69

SKSC Capitation Rates / RC VI Rates			
April 1, 2020 - July 31, 2020			
REGION	MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Eastern	$10,959.59	$924.30	$11,883.89
Western	$10,959.59	$924.30	$11,883.89

SKSC Capitation Rates / RC VI Rates			
August 1, 2020 - December 31, 2020			
REGION	MEDICAL COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Eastern	$10,841.39	$924.30	$11,765.69
Western	$10,841.39	$924.30	$11,765.69