COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

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CONTRACTOR LEGAL NAME: Steward Medicaid Care Network, Inc. **(and d/b/a):**		**COMMONWEALTH DEPARTMENT NAME:** Executive Office of Health and Human Services **MMARS Department Code:** EHS	
Legal Address: (W-9, W-4): 1900 North Pearl St., Suite 2400, Dallas, TX 75201		**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108	
Contract Manager: Jennie Vital	**Phone:** 617-309-0495	**Billing Address (if different):**	
E-Mail: jennie.vital@steward.org	**Fax:**	**Contract Manager:** Alejandro Garcia Davalos	**Phone:** 781-227-1913
Contractor Vendor Code: VC0000854705		**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov	**Fax:**
Vendor Code Address ID (e.g., "AD001"): AD001. **(Note: The Address ID must be set up for EFT payments.)**		**MMARS Doc ID(s):** N/A	
		RFR/Procurement or Other ID Number: BD-22-1039-EHS01-ASHWA-71410	

☐ **NEW CONTRACT**

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

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

☒ **CONTRACT AMENDMENT**

Enter **Current Contract End Date *Prior*** to Amendment: **December 31, 2027.**
Enter **Amendment Amount**: $ no change. (or "no change")

AMENDMENT TYPE: (Check one option only. Attach details of amendment changes.)

☒ **Amendment to Date, Scope or Budget** (Attach updated scope and budget)
☐ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget)
☐ **Contract Employee** (Attach any updates to scope or budget)
☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

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

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

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

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

This **Amendment 3 to the First Amended and Restated Primary Care ACO Contract** with Steward Medicaid Care Network updates the contract language, deletes and replaces certain Appendices effective January 1, 2024.

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

☐ 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.
☒ 2. may be incurred as of **January 1, 2024**, 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, 2027,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

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

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:

X: _____ **Date:** 10/17/2024
(Signature and Date Must Be Captured At Time of Signature)
Print Name: Joseph Weinstein, MD
Print Title: President

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: _____ **Date:** 11/05/2024
(Signature and Date Must Be Captured At Time of Signature)
Print Name: Mike Levine
Print Title: Assistant Secretary for MassHealth

AMENDMENT #3

TO THE

FIRST AMENDED AND RESTATED

PRIMARY CARE ACCOUNTABLE CARE ORGANIZATION CONTRACT

FOR THE

ACCOUNTABLE CARE ORGANIZATION PROGRAM

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

WHEREAS, EOHHS and the Contractor last amended and restated the Contract effective January 1, 2024, (the First Amended and Restated Accountable Care Partnership Plan Contract);

WHEREAS, EOHHS and the Contractor amended the Contract through Amendment #1 (January 1, 2024) and Amendment #2 (January 1, 2024);

WHEREAS, in accordance with **Section 5.12** of the Contract, EOHHS and the Contractor desire to amend the Contract effective January 1, 2024; and

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

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

1. **Section 1, Definitions, Enrollee Incentive,** is hereby amended by deleting "in a targeted behavior, such as guideline-recommended clinical screenings, Primary Care Provider (PCP) visits, or Wellness Initiatives" and inserting in place thereof "in behaviors impacting their health and wellness".

2. **Section 1, Definitions, Homeless Management Information Systems (HMIS)** is hereby amended by deleting the section in its entirety and inserting in place thereof:

   "**Homeless Management Information Systems (HMIS)** – A software application that is a federal requirement for agencies that receive funding for services/housing for people experiencing homelessness. Each Continuum of Care is required to develop and implement a local HMIS designed to record and store client-level information on the

characteristics and provision of housing and services to individuals and families experiencing or at risk of homelessness."

3. **Section 2.3.F** is hereby amended by inserting a new **Section 2.3.F.4** as follows:

"3. The Contractor shall, as further directed by EOHHS, implement policies and procedures that ensure appropriate discharges and transitions of care for Enrollees with complex or chronic medical needs, including but not limited to, post-discharge placement in a nursing facility or rehabilitation facility.

a. Such policies and procedures shall:

1) Be incorporated into the Contractor's protocols for Transitional Care Management with all Network Hospitals;

2) Include identifying nursing and rehabilitation facilities with bed availability that offer specialized services to meet member specific needs including but not limited to psychiatric units, traumatic brain injury units, and bariatric equipment;

3) Identify a dedicated point of contact at the Contractor for Network Hospitals to liaise with;

4) Create a process by which the Contractor shall obtain information from the Network Hospital about the Enrollee's health conditions, required referrals, and any barriers in obtaining placement; and

5) Include strategies for addressing challenges in obtaining an appropriate placement for the Enrollee, including contracting with additional facilities.

b. The Contractor shall respond to EOHHS requests for information on progress toward finding placement for Enrollees in a timely manner; and

c. The Contractor shall contact or otherwise obtain information on Enrollees discharged into the community to ensure their health needs are met."

4. **Section 2.10.D** is hereby amended by deleting the section in its entirety and inserting in place thereof the following:

"D. The Contractor may implement Enrollee Incentives, as appropriate. The Contractor shall:

1. Take measures to monitor the effectiveness of such Enrollee Incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

2. Assure that all such Enrollee Incentives comply with all applicable state and federal laws; and

3. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Enrollee Incentives."

5. **Section 2.12.B.2** is hereby amended by deleting "shall submit its initial Population and Community Needs Assessment, as further specified by EOHHS, and".

6. **Section 2.12.C** is hereby amended by:

    a. Deleting **Section 2.12.C.2.f.3** in its entirety and inserting in place thereof "[Reserved]".

    b. Deleting **Section 2.12.C.2.h** in its entirety and inserting in place thereof "[Reserved]".

    c. In **Section 2.12.C.4.d.1**, deleting "including reporting on Health Equity, anti-racism, implicit bias, and related staff trainings,".

    d. Deleting **Section 2.12.C.4.d.3** in its entirety and inserting in place thereof "[Reserved]".

    e. Deleting **Section 2.12.C.4.e** in its entirety and inserting in place thereof "[Reserved]".

    f. In **Section 2.12.C.6,** deleting "and its annual Health Equity summary reports".

7. **Section 2.14.A** is hereby amended by inserting a new **Section 2.14.A.1.b.2.d** as follows:

    "d) Ensure that Participating Primary Care Practice PID/SLs adhere to the notification requirements set forth in **Section 2.2.A.4.b**. In the event of an unanticipated Participating Primary Care Practice PID/SL closure, EOHHS may remove the Participating Primary Care Practice PID/SL from the Primary Care Sub Capitation Program and make adjustments as further specified by EOHHS.

8. **Section 2.14.B** is hereby amended by:

    a. In **Section 2.14.B.1.g**, deleting "Contract Years" at the end of the second sentence and inserting in place thereof "Contract Year 1 to Contract Year 2 and shall not roll over any funds into Contract Year 3".

    b. In Section **2.14.B.1.j**, deleting "of" in the first line and inserting in place thereof "at least 30 days prior to"

    c. Deleting **Section 2.14.B.5.f** in its entirety and inserting in place thereof "[Reserved]".

    d. Inserting a new **Section 2.14.B.13** as follows:

        "13. Requirements for Sunsetting the Flexible Services Program

            By December 31, 2024, the Contractor shall ensure the completion or termination of all Flexible Services program activities described in this section. In addition to the Enrollee notification requirements described in **Section 2.14.B.1.j**, the Contractor shall:

a. Establish policies and procedures that support the completion or termination of all Flexible Services program activities by the end of Contract Year 2. Such policies and procedures shall include communications to Social Services Organizations, and other individuals and entities involved in administering Flexible Services.

b. Notify and communicate about the following to Enrollees receiving Flexible Services, no later than December 1, 2024:

    1) Service termination, including specific details of what Enrollees can anticipate;

    2) Options available to Enrollees, including other HRSN supports and community resources; and

    3) As directed by EOHHS, information about HRSN services that the Contractor will provide as of January 1, 2025.

c. Ensure that all payments for Flexible Services are made to Social Service Organizations by no later than February 15 of Contract Year 3; and

d. In addition to the requirements set forth in **Section 2.14.B.5.i**, return to EOHHS any unspent Flexible Services allocation funds."

9. **Section 2.14.C** is hereby amended by inserting ", including, but not limited to, conducting a readiness review as set forth in **Section 2.5.D.2** of this Contract and as further specified by EOHHS" after "Contract Year 2025".

10. **Section 2.14** is hereby amended by inserting a new **Section 2.14.D** as follows:

"D. Participation in Evaluation of Massachusetts' 1115 Demonstration Waiver

As directed by EOHHS, the Contractor shall participate in the independent evaluation of Massachusetts' 1115 Demonstration Waiver, including by responding to requests for information, providing qualitative feedback, and sharing data as appropriate with EOHHS and its partners."

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

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

Appendix B
EOHHS Accountable Care Organization Quality and Health Equity Appendix

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

Section 1.1. OVERVIEW OF QUALITY AND HEALTH EQUITY PERFORMANCE AND SCORING

Section 1.2 SCORING METHODOLOGY FOR ACO QUALITY SCORE

- **A. List of Quality Measures for ACO Quality Score**
- **B. Measure Level Scoring Methodology (Achievement and Improvement Points)**
- **C. Domain Level Scoring Methodology**

Section 1.3 SCORING METHODOLOGY FOR ACO QUALITY AND EQUITY INCENTIVE PROGRAM (QEIP) HEALTH EQUITY SCORE

Section 1.4 SCORING METHODOLOGY FOR COMMUNITY PARTNERS QUALITY SCORE

- **A. List of Quality Measures for CP Quality Score**

Section 1.5 METHODOLOGY FOR ESTABLISHING PERFORMANCE BENCHMARKS FOR QUALITY MEASURES

Section 1.6 QUALITY AND HEALTH EQUITY PERFORMANCE FINANCIAL APPLICATION

Section 1.1 Overview of Quality Performance and Scoring and Health Equity Performance and Scoring

The Contractor shall receive, for each Performance Year, an ACO Quality Score that shall determine the Quality Incentive payment amount available to the Contractor as prescribed in **Section 2.10** of the Contract. The Contractor shall also receive, for each Performance Year, an ACO Health Equity Score that shall determine the Quality and Equity incentive payment amount available to the Contractor as prescribed in **Sections 2.12** and **2.12.E** of the Contract. The Contractor shall also receive, for each Performance Year, a CP Quality Score (calculated by EOHHS) for each Community Partner subcontractor as described in **Section 2.4.E** of the Contract. The CP Quality Score shall be used in the determination of incentive payments made by the Contractor to each of its subcontracted CPs.

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

Section 1.2 Scoring Methodology for ACO Quality Score

The Contractor's Quality Score is based on the Contractor's performance across a set of benchmarks and improvement targets for individual quality measures that are grouped into three domains. An additional bonus element is also included for PY2024 based on an assessment of Electronic Quality Measurements/Electronic Clinical Data System readiness, as specified by EOHHS. EOHHS will weight and sum the Contractor's performance across all domains and then apply results of the bonus element to calculate one overall ACO Quality Score per performance year. For any measure where the Contractor does not meet minimum denominator requirements, as determined by EOHHS, then the measure's weight will be equally distributed to other measures within the same domain.

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

A. List of Quality Measures for ACO Quality Score

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

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

See Exhibit 2 for the list of Quality Measures.

EXHIBIT 2 – ACO Quality Measures

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

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
		Percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery				
	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[1]
	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Hybrid	CMS	0418	2023

[1] EOHHS will calculate pay for performance metrics for ages 1 through 5 only. For ages 6 – 20, this subpopulation will be for monitoring purposes only.

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Care Coordination/ Care for Acute and Chronic Conditions	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 days	Claims	NCQA	3489	2023
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	Percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who has a follow up visit for AOD	Claims	NCQA	3488	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	2023
	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose	Hybrid	NCQA	0018	2024

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
		blood pressure was adequately controlled				
	Comprehensive Diabetes Care: HBA1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059	2024
	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800	2024
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004	2024

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Member Experience	Overall Care Delivery	Composites related to overall experience (e.g., Willingness to Recommend, Communications)	Survey	AHRQ	N/A	2023
	Person-Centered Coordination/Integration of Care	Composites related to coordination of care (e.g., referrals, services etc.) and knowledge of the patient	Survey	AHRQ	N/A	2023
N/A	Bonus Element: Electronic Clinical Quality Measure Readiness	Assessment and/or reporting of ACO readiness in meeting electronic-based clinical quality measure results on Enrollees	Survey	EOHHS	N/A	2024

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

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

	Pressure and *Comprehensive Diabetes Care: HBA1c Poor Control*					

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:

a. EOHHS will establish an "attainment threshold" and a "goal benchmark" for each Quality Measure

(i) "Attainment threshold" sets the minimum level of performance at which the contractor can earn achievement points

(ii) "Goal benchmark" is a high performance standard above which the Contractor earns the maximum number of achievement points (i.e., 10 points)

b. EOHHS will calculate the Contractor's performance score on the Quality Measure based on the measure specifications

c. EOHHS will award the Contractor between zero (0) and ten (10) achievement points as follows:

(i) If the Contractor's performance score is less than the attainment threshold: 0 achievement points

(ii) If the Contractor's performance score is greater than or equal to the goal benchmark: 10 achievement points

(iii) If the performance score is between the attainment threshold and goal benchmark: achievement points earned are determined by the formula:

(a) 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:

a. 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.

b. 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.

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

(i) 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)]

(ii) 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%.

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

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

(iv) 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%.

(v) The Improvement Target is based on the higher of the original baseline or any year's performance prior to the current PY. This is intended to avoid rewarding regression in performance.

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

(vi) There are several special circumstances:

(a) *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.

(b) *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

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%	

An assessment of electronic-based quality measure readiness (e.g., Electronic Clinical Quality Measures (eCQM), and Electronic Clinical Data Systems (ECDS)) shall be integrated into the overall ACO Quality Score as a bonus element for PY2024. The assessment shall be scored on an all-or-nothing basis, with possible scores equaling zero or 100%. Any ACO achieving 100% on the bonus will earn a total of 5.0 points added to the sum of the weighted domain score, resulting in an overall quality score. Note: the sum of weighted domains and the 5.0 point bonus may not exceed the overall quality score maximum of 100%.

EXHIBIT 6 – Example Calculation of Weighted Domain Scores and Bonus

Example Calculations of Weighted Domain Scores and Bonus				
	Domain	**Weight**	**Score**	**Weighted Domain Score**
Example	Preventative and	45%	75.0	33.75

	Pediatric Care			
	Care Coordination / Care for Chronic & Acute Conditions	40%	70.0	28.00
	Member Experience	15%	72.0	10.8
	Total	100%	N/A	72.55
	Bonus	N/A	5.0 points	N/A
	Total of weighted domains = 72.55			
	Total bonus: 5.0 points			
	Sum of weighted domains and bonus points: 72.55 + 5.0 = 77.55 points			
	Overall Quality Score = 77.55%			

Section 1.3 Scoring Methodology for ACO Quality & Equity Incentive Program (QEIP) Health Equity Score

A. Performance Year 1 (CY2023) requirements for the ACO QEIP can be found in Attachment 1 to this Appendix.

B. Performance Years 2-5 (CY2024-2027) requirements for the ACO QEIP are forthcoming and will be provided in Attachment 2 to this Appendix.

Section 1.4 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 7 and 8 below. EOHHS will weight each CP's CP Quality Score by the volume of that CP's enrollment within the ACO relative to the volume of all other CP subcontractors within the same ACO. As further specified by EOHHS, EOHHS shall use the weighted CP Quality Score to determine the Contractor's payment to each CP based on the CP's quality performance. In addition to the above methodology, EOHHS may establish additional quality incentives designed to reward the Contractor's higher performing subcontracted CPs.

A. Quality Measures for CP Quality Score

EXHIBIT 7 – BH CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.
Follow-up with BH CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP	Claims	EOHHS	NA

Measure Name	Description	Data Source	Measure Steward	NQF No.
	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	Claims	NCQA	1932

Measure Name	Description	Data Source	Measure Steward	NQF No.
	during the measurement year			
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment	Claims	NCQA	0105
Treatment Plan Completion	TBD	Claims	EOHHS	NA
Member Experience	TBD	Survey	EOHHS	NA

EXHIBIT 8 – 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

Measure Name	Description	Data Source	Measure Steward	NQF No.
Member Experience	TBD	Survey	EOHHS	NA

Section 1.5 Methodology for Establishing Performance Benchmarks for Quality Measures

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

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

Section 1.6 Quality Performance Financial Application

The Contractor's ACO Quality Score and ACO Health Equity Score will be applied to performance incentive payment as described in **Sections 2.10.C and 2.12.E.** Community Partner Quality Scores will be applied to incentive payments to CP subcontractors as described in **Section 2.4.E.**

ATTACHMENT 1

MassHealth "ACO Quality and Equity Incentive Program" Performance Year 1 Implementation Plan

Table of Contents

SECTION 1. BACKGROUND AND OVERVIEW OF THE ACCOUNTABLE 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 AQEIP for the first PY from April 1, 2023-December 31, 2023, of the Contract (April 1, 2023 – December 31, 2027.) Information pertaining to PYs 2-5, representing Calendar Years 2024-2027, will be forthcoming.

SECTION 2. ACCOUNTABLE CARE ORGANIZATION QUALITY AND EQUITY INCENTIVE PROGRAM (AQEIP) DOMAINS AND GOALS

A. Overview of Targeted Domains for Improvement in the AQEIP

For the AQEIP, the Contractor is incentivized to pursue performance improvements in the domains specified in Table 1.

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

Domain 1: Demographic and Health-Related Social Needs Data	The Contractor 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	The Contractor 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	The Contractor 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 AQEIP

Goals for each AQEIP domain are summarized below:

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

    a. The Contractor is 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. The Contractor is 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. The Contractor is 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, the Contractor 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. The Contractor is 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), the Contractor's 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;

      (ii) Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics that account for clinical and social risk factors.

   c. For at least the last two Performance Years (PY2026 and PY2027), the Contractor's 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

   The Contractor is 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. AQEIP 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 AQEIP holds the Contractor accountable to metrics listed in Table 2 evaluating contributory health system level interventions in each performance domain.

Table 2. AQEIP 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
Equity Improvement	Performance Improvement Projects (*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	Achievement of External Standards for Health Equity (EOHHS)	P4R
	Patient Experience: Cultural Competency (*AHRQ)*	P4P

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

Recognizing that taking on accountability for equity is new for most ACOs, 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 AQEIP 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 Data Completeness (EOHHS)	• **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 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 ACPPs will be submitted via the existing encounter submission process, using the enhanced Member File Specification. Data collected by PCACOs will be submitted via a process as further specified by EOHHS.	July 31, 2023 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 Contractor for intended use in screening members beginning in PY2; the selected tool(s) must meet requirements for screening tools for	July 31, 2023 October 27, 2023

	the "Screening for Social Drivers of Health" metric and Section 2.5 of the ACPP and MCO Contracts and Section 2.3 of the PCACO Contract; 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 community resources and support services available to members who screen positive for HRSNs. 4) An implementation plan describing how the Contractor 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 Contractor when the screening is conducted, and how the CP will communicate results of the screening with the Contractor.	
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
Performance Improvement Projects (EOHHS)	Complete and timely submission to EOHHS of quarterly deliverables for at least one Hospital-partnered Performance Improvement Project as follows: • Early Q3: ACO Key Personnel/Institutional Resources Document • Early Q3: Equity Improvement Intervention Partnership Form • Q3: Hospital Key Contact Form and the Mid-Year Planning Report • Q4: Equity Improvement Intervention Planning Report, a comprehensive plan that incorporates information about	Early Q3: July 21, 2023 Q3: September 30, 2023 Q4: December 31, 2023

	Performance Improvement Project (PIP) goals and objectives, baseline data, proposed interventions, and tracking measures. The PIP Planning/Baseline Report will serve as the blueprint for PIP Implementation in PY2.	
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 Contractor's Disability-Competent Care (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 Contractor'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.	December 1, 2023

Domain 3. Capacity and Collaboration		
Achievement of External Standards for Health Equity (EOHHS)	Complete and timely submission to EOHHS of the NCQA Health Equity Accreditation Report.	December 31, 2023
Patient Experience: Cultural Competency (AHRQ)	Performance on a subset of items from CAHPS survey reflective of cultural competency during MY23 as selected by EOHHS.	N/A

SECTION 4. AQEIP PAYMENT FOR PERFORMANCE YEAR 1

EOHHS will pay the Contractor based on the Contractor's health equity score in accordance with **Section 4.6** of the ACPP Contract and **Section 4.2** of the PCACO Contract. EOHHS will make a one-time payment to the Contractor after the health equity score has been finalized.

SECTION 5. AQEIP ACCOUNTABILITY FRAMEWORK FOR PERFORMANCE YEAR 1

EOHHS will hold the Contractor accountable for its performance on the AQEIP performance measures. Total incentive amounts 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 Contractor met performance requirements summarized in Table 3, as determined by EOHHS.

Table 4. Performance Year 1 AQEIP Metric Weights

Subdomain	ACO 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*)	10

Equity Improvement	Equity Improvement Interventions (*EOHHS*)	10
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	10
	Disability Competencies (*EOHHS*)	10
	Accommodation Needs Met (EOHHS)	10
Domain 3. Capacity and Collaboration		**25**
Capacity	Achievement of External Standards for Health Equity (EOHHS)	10
	Patient Experience: Cultural Competency (*AHRQ)*	15

ATTACHMENT 2
PERFORMANCE YEARS 2024-2027
IMPLEMENTATION PLAN FOR MASSHEALTH ACCOUNTABLE CARE ORGANIZATION QUALITY AND EQUITY INCENTIVE PROGRAM

Table of Contents

SECTION 1. BACKGROUND AND OVERVIEW OF THE ACCOUNTABLE CARE ORGANIZATION QUALITY AND EQUITY INCENTIVE PROGRAM

A. Overview of Statewide Approach to Advance Healthcare Quality and Equity

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 PY2-5 Implementation Plan for the ACO Quality and Equity Incentive Program

This ACO Quality and Equity Incentive Program (AQEIP) Implementation Plan provides additional detail related to implementation of MassHealth's AQEIP for Performance Years (PYs) 2-5 from January 1, 2024 – December 31, 2027, of the Contract (April 1, 2023 – December 31, 2027.) Additional detail may be forthcoming for future program years.

SECTION 2. ACO QUALITY AND EQUITY INCENTIVE PROGRAM (AQEIP) DOMAINS AND GOALS

A. Overview of Targeted Domains for Improvement in the AQEIP

For the AQEIP, the Contractor is incentivized to pursue performance improvements in the domains specified in Table 1.

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

Domain 1: Demographic and Health-Related Social Needs Data	The Contractor 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, 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	The Contractor 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 a preferred language other than English; preventive, perinatal, and pediatric care services; care for chronic diseases and behavioral health; and care coordination.
Domain 3: Capacity and Collaboration	The Contractor 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 AQEIP

Goals for each AQEIP domain are summarized below:

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

    a. The Contractor shall submit to MassHealth an assessment of beneficiary-reported demographic and HRSN data adequacy and completeness for purposes of the AQEIP by July 1, 2023.

    b. The Contractor is 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).

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

d. The Contractor is incentivized to meaningfully improve rates of HRSN screenings from the baseline period by the end of Performance Year 5 (CY 2027). To meet this goal, the Contractor 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. The Contractor is incentivized for performance on metrics such as those related to access to care (including for individuals with a preferred language other than English and/or disability); preventive, perinatal, and pediatric care; care for chronic diseases; behavioral health; care coordination; and/or patient experience.

b. Metric performance expectations shall include, at a minimum:

(i) Reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health-related social needs; and/or defined by other individual- or community-level markers or indices of social risk;

(ii) Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics that account for clinical and social risk factors found through analysis to be associated with lower performance on such metrics and/or other appropriate individual/community-level markers or indices of social vulnerability;

(iii) Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

c. For up to the first three PYs, performance will be based on expectations described in 2(b)(i) and 2(b)(ii), above. For at least the last two PYs, performance will also be based on expectations described in 2(b)(iii), above.

3. Capacity and Collaboration Domain Goals

a. The Contractor is 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. AQEIP PERFORMANCE YEAR 2-5 METRICS

Performance years 2-5 of the AQEIP will hold the Contractor accountable to metrics evaluating performance in each AQEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. Technical specifications for the AQEIP PY2-5 metrics, which may be updated annually or more frequently as necessary. A summary of the AQEIP metrics and anticipated payment status in PY2-5 are provided in Table 2.

Table 2. AQEIP PY 2-5 Metrics

Subdomain	**Metric (*Steward)***	**Anticipated payment status***			
		2024	**2025**	**2026**	**2027**
Domain 1. Demographic and Health-Related Social Needs Data					
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	P4R	P4P	P4P	P4P
Health-Related Social Needs Screening	Health-Related Social Needs Screening (EOHHS)	P4R	P4P	P4P	P4P
Domain 2. Equitable Access and Quality					
Equity Reporting	Quality Performance Disparities Reduction (*EOHHS*)	P4R	P4R	P4P	P4P
Equity Improvement	Equity Improvement Interventions (*EOHHS*)	P4P	P4P	P4P	P4P
Access	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English (*EOHHS*)	P4R	P4P	P4P	P4P
	Disability Competent Care (*EOHHS*)	P4P	P4P	P4P	P4P
	Disability Accommodation Needs Screening *(EOHHS)*	P4R	P4P	P4P	P4P
Domain 3. Capacity and Collaboration					
Capacity	Achievement of External Standards for Health Equity (EOHHS)	P4R	P4P	P4R	P4R
	Member Experience: Communication, Courtesy, and Respect (EOHHS/*AHRQ)*	P4R	P4P	P4P	P4P

*P4R= Pay for Reporting, P4P= Pay for Performance. Specific performance trajectories are subject to change. Reporting/performance requirements for each measure described in forthcoming metric technical specifications.

The anticipated reporting expectations for PY2 are summarized in Table 3; detailed reporting and performance expectations for PY2 are included in metric technical specifications. Each report outlined in Table 3 shall be submitted by the Contractor in a form, format, and frequency to be further specified by EOHHS. Additional and/or revised reporting expectations for PY3-5 will be provided prior to the start of each performance year.

Table 3. Reporting Expectations for PY2

Measure Name	**Reporting Expectations for PY2 (to be further specified by EOHHS)**
Domain 1: Demographic & HRSN Data	
RELDSOGI Data Completeness	1. Submission of "Member Data and Member Enrollment" file 2. Submission of RELDSOGI Mapping Report inclusive of a plan to develop capacity to capture date stamps by PY5
Health-Related Social Needs Screening	1. Submission of administrative and/or supplemental HRSN data
Domain 2: Equitable Access & Quality	
Quality Performance Disparities Reduction	1. Submission of quality data stratified by race and ethnicity
Equity Improvement Interventions	1. Submission of PIP 2 Mid-Year Planning Report 2. Submission of PIP 1 and PIP 2 implementation reports
Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	1. Submission of Language Access Self-Assessment Survey 2. Submission of Provision of Interpreter Services Data
Disability Competent Care	1. Submission of Disability Competency Training Plan 2. Submission of Disability Competency Training Report
Disability Accommodation Needs Screening	1. Submission of Disability Accommodation Needs Assessment Report
Domain 3: Capacity & Collaboration	
Achievement of External Standards for Health Equity	1. Submission of External Standards for Health Equity Report
Member Experience: Communication, Courtesy, and Respect	1. Submission of Member Experience Assessment Report

Section 4. AQEIP Payment for Performance Years 2-5

MassHealth will pay each Contractor based on the Contractor's health equity score in accordance with **Section 4.6** of the ACPP Contract and **Section 4.2** of the PCACO Contract. EOHHS will make a one-time payment to the Contractor after the health equity score has been finalized.

Section 5. AQEIP Accountability Framework for Performance Year 2-5

A. ACO Accountability to MassHealth for the AQEIP

MassHealth will hold the Contractor accountable for its performance on the AQEIP performance measures. MassHealth's anticipated framework for the AQEIP PAM, which may be adjusted annually as needed (for example to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including benchmarks, improvement targets and measure score calculation approach, will be described in each forthcoming measure specification.

1. **Benchmarking:** MassHealth will establish performance targets or benchmarks no later than the start of the first pay-for-performance period for the metric.

    a. Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period.

    b. Establishment of benchmarks will be informed by inputs such as initial AQEIP performance data, historical data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.

2. **Improvement Targets:** MassHealth will establish performance improvement targets for performance metrics, as applicable, no later than the start of the first pay-for-performance period for the metric.

    a. Specific improvement targets and the approach for each measure will be set to apply to the full applicable performance period.

    b. The approach and actual improvement target may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point increase, absolute percentage point increases, set milestones and/or goals for improvement.

3. **Performance Measure Score Calculation**: The performance measure scoring approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.

a. **Pay-for reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the Contractor will receive full points or credit for the metric if reporting is completed according to each measure's technical specifications.

b. **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices, described below.

(i) Measure scoring will include the following components for each measure:

1. Attainment points ranging from 0-10 points

2. Improvement points ranging from 0-10 points

3. Potential bonus points (with a cap) to ensure all participating ACOs have incentive to improve, including high-performing ACOs

(ii) Performance measure scores for each measure will be defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows:

Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.

(iii) Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows:

Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).

4. **Domain Score Calculation**: The domain scoring and approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring includes the following components:

a. Using the predetermined weights specified in Table 3, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight:

Domain Score = Sum of each (Performance Measure Score Performance Measure Weight).*

b. If the Contractor is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.

5. **Health Equity Score Calculation**: The overall Health Equity Scoring approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. The overall Health Equity Score includes the following components. Using the predetermined weights specified in Table 3, a health equity score will be calculated by taking each domain score and calculating the sum of each domain score multiplied by its respective domain weight:

*Health Equity Score = Sum of each (Domain Score * Domain Weight).*

The final Health Equity Score will be used to calculate the Contractor's earned incentive payment.

Table 4. PY 2-5 AQEIP Metric Weights

Domain*	Measure Name	Anticipated Measure Weight (%) by Performance Year				Domain Weight (%)
		2024	2025	2026	2027	
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	10	10	15	15	25
	Health-Related Social Needs (HRSN) Screening	15	15	10	10	
EAQ	Quality Performance Disparities Reduction	10	10	20	20	50
	Equity Improvement Interventions	10	10	5	5	
	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	10	10	10	10	
	Disability Competent Care	10	10	5	5	
	Disability Accommodation Needs Screening	10	10	10	10	
CC	Achievement of External Standards for Health Equity	15	15	10	10	25
	Member Experience: Communication, Courtesy, and Respect	10	10	15	15	
TOTAL						**100**

*DHRSN=Demographic and Health-Related Social Needs Data; EAQ=Equitable Access and Quality; CC=Capacity and Collaboration

APPENDIX F
ACO REPORTING REQUIREMENTS

This Appendix summarizes certain reporting requirements described in the Contract. This summary does not supersede contract language, nor does it capture all possible report requests as part of the Readiness Review. EOHHS may update these requirements from time to time. The Contractor shall submit corresponding Certification Checklists of all reports/submissions listed in **Appendix F** within the timelines specified herein. The Contractor may include a narrative summary to reports/submissions and may include graphs that explain and highlight key trends. All reports must be submitted via OnBase, the EOHHS Contract Management system, unless otherwise indicated below in the *"Target System"* column. Numbering sequence and Report Title that will appear in the OnBase system can be found in **BOLD** in the *"Name of Report"* column.

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

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

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

Reporting Deliverable Schedule

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

   CY Quarter 1: January 1 – March 31

   CY Quarter 2: April 1 - June 30

   CY Quarter 3: July 1 – September 30

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

   January 1 – June 30

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

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

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

B. Contract Management Reports

Certain Contract Management Reports have submission requirements in addition to those listed in the Target System column. Please use the following key:

[1] The Contractor shall additionally send report via regular email to the Contract Manager (in addition to using the Target System).

[2] The Contractor shall additionally send report via secure email to the Contract Manager (in addition to using the Target System).

[3] The Contractor shall notify its Contract Manager upon submission of the report using the Target System.

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-03	**CM-03 Member Telephone Statistics** Member Telephone Statistics	Monthly	OnBase
CM-04	**CM-04 Member Education and Related Orientation, Outreach Materials** Member Education and Related Orientation, Outreach Materials (including enrollment materials for MH Customer Service Center (CSC)	Ad-Hoc	OnBase[1]
CM-07	**CM-07 Marketing Materials** Marketing Materials *(60 days in advance of use, including materials to be distributed at Contractor and non-Contractor sponsored health fairs or community events)*	Ad-Hoc	OnBase[1]
CM-08	**CM-08 Marketing Materials- Annual Executive Summary** Marketing Materials- Annual Executive Summary (including a written statement that all of the Contractor's marketing plans and materials are accurate and do not mislead, confuse, or defraud Members or the state)	Annual	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-17-A	**CM-17-A Enrollee Inquiries Summary** Inquiries and Grievances Summary: Enrollee Inquiries	Annual	OnBase
CM-17-B	**CM-17-B Enrollee Grievances Summary** Inquiries and Grievances Summary: Enrollee Grievances	Annual	OnBase
CM-17-F	**CM-17-F - Grievances Report (per 1,000 Enrollees)** Grievances Report (per 1,000 Enrollees)	Monthly	OnBase
CM-18	**[RETIRED]**		
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[3]
CM-23	**CM-23 Notification of Termination of Material Subcontractor** Notification of Intention to Terminate a Material Subcontractor (Notification: Same Day)	Ad-Hoc	OnBase[1]
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[1]
CM-25	**CM-25 Material Subcontractor List Annual Summary** Material Subcontractor List Annual Summary	Annual	OnBase
CM-31	**CM-31 Notification of Federally Required Disclosures** Notification of Federally Required Disclosures (in accordance with Section 5.26.A)	Ad-Hoc	POSC[3]
CM-43-A	**CM-43-A Holiday Closures and Other Contractor Office Closures Annual** Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annual	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
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[3]
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[3]
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[1]
CM-49	**CM-49 Written Disclosure of Identified Prohibited Affiliations** Written Disclosure of Identified Prohibited Affiliations	Ad-Hoc	OnBase[3]
CM-50	**[RETIRED]**		
CM-57	**[RETIRED]**		
CM-58	**CM-58 Application for MassHealth Data [for External Research Projects]** Application for MassHealth Data	Ad hoc	Email
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annual	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[2]

C. Care Coordination

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CC-01	**CC-01 Care Needs Screening** Aggregate Care Needs Screening Completion Rates	Ad-hoc	OnBase
CC-02	**CC-02 HRSN Screening** HRSN Screening	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 Strategy** Summary of the Contractor's performance management strategy of the CP Program and overview of Contractor's CP Program performance.	Annually	OnBase
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 significant CP performance concerns, Performance Improvement Plans, or Corrective Action Plans** As described in Section 2.4.E.3.b-c, notification within 5 business days of early warning indicators of significant CP performance concerns, and/or implementation of Performance Improvement Plans, 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	Ad hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Care Management		
CC-10	**CC-10 Care Management Enrollment** Care Management Enrollment	Monthly	SFTP
CC-11	**[RETIRED]**		

D. Financial Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-43-A	**FR-43 Primary Care Sub-Capitation Payment Tracking Report - Monthly** Primary Care Sub-Capitation Payment Tracking Report	Monthly	SFTP
FR-43-B	**FR-43 Primary Care Sub-Capitation Payment Tracking Report – Ad Hoc** Primary Care Sub-Capitation Payment Tracking Report	Ad-Hoc	SFTP

E. ACO Health Equity Reporting

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
HQ-23	**[RETIRED]**		
HQ-24	**HQ-24 ACO/MCO Health Quality and Strategic Plan**	Ad-Hoc	OnBase

F. Operations Reports

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

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
OP-06	**OP-06 Address Change File** Address Change File	Bi-Weekly	OnBase
OP-07	**OP-07 Multiple ID File** Multiple ID File	Bi-Weekly	OnBase
OP-08	**OP-08 Date of Death Report** Date of Death Report	Bi-Weekly	OnBase

G. Program Integrity

ACO 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 Secure E-mail
PI-08	**PI-08 - Self-Reported Disclosures** Self-Reported Disclosures	Ad-Hoc	OnBase

H. Quality Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-01	**QR-01 QM/QI Program Description/Workplan** Written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor's QM/QI initiatives.	Annually	OnBase
QR-07	**QR-07 Clinical Quality Measures**	Annually	Quality Vendor
QR-08	**QR-08 Supplemental Data for Clinical Quality** Supplemental data files (Format for submission determined and communicated by MassHealth's Comprehensive Quality Measure Vendor (CQMV). *(Note: Due by May 31st of each year)*	Annually	Inter-change

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-09	**QR-09 Validation of Performance Measures** Validation of Performance Measures	Annually	EQRO