APPENDIX A
MCO REPORTING REQUIREMENTS

Effective xx/xx/xxxx

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.

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 fifth business 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, unless otherwise specified (Contract Year: January 1 -- December 31)
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**

At the time of first quarterly submission and subsequently thereafter - 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.

B. Contract Management Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
CM-1	Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs) *(including Health care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs)*	Notification: Within 7 calendar days of occurrence
CM-2	Summary of Serious Reportable Events (SREs) and Provider Preventable Conditions (PPCs)	Annual Report
CM-3	Member Telephone Statistics	Monthly
CM-4	Member Education and Related Orientation, Outreach Materials (including enrollment materials for MH Customer Service Center (CSC)	Ad-Hoc
CM-5	Provider Directory	Ad-Hoc
CM-6	Provider Manual	Ad-Hoc
CM-7	Marketing Materials *(including materials to be distributed at Contractor and non-Contractor sponsored health fairs or community events)*	Ad-Hoc
CM-8	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
CM-9	Significant Changes in Provider Network Notification	Notification: Same Day

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
CM-10	Summary of Access and Availability: a. Description of Ensuring Enrollees have access to Medically Necessary services b. Summary of Significant Changes in Provider Network c. PCP Network Turnover Rate d. Geographic Access Report for Adult PCPs, Pediatric PCPs, and acute inpatient hospitals (demonstrating access by geography) e. PCP to Enrollee Ratio Report (showing open and closed adult PCPs and pediatric PCPs/Panels per number of Enrollees) f. PCP Assignment Accuracy g. Enrollee Change of PCP h. Specialists: Specialists to Enrollee Ration; High Volume Specialists, Psychiatrists and OB/GYN Geographic Access) i. Timeliness of Care (Describe system in place to monitor and document access and appointment scheduling standards) j. Experience Survey k. Use of Out-of- Network Providers l. Pharmacy i. Pharmacy Network Geographic Access ii. Non-Compliant Pharmacies, if applicable iii. Mail Order Pharmacy Program, if applicable	Annual
CM-11	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
CM-12	Claims Processing Report	Monthly
CM-13	Provider Financial Audit	Annual
CM-14	Notification of Final Internal Upheld Appeals Denial Decisions	Notification: Next Day
CM-15	Notification of Potential Board of Hearing Cases	Notification: Same Day
CM-16	Implementation of Board of Hearing Decision (within 30 days of receipt)	Ad-Hoc

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
CM-17	Inquiries, Grievances, Internal Appeals and Board of Hearing Summary a. Enrollee Inquiries b. Enrollee Grievances c. Enrollee Internal Appeals (Level I and II) d. Enrollee BOH Appeals	Annual
CM-18	Fraud and Abuse Notification (within 10 days) and Activities	Ad-Hoc
CM-19	Fraud and Abuse Report	Annual
CM-20	Notification of Failed Provider Enrollment, Credentialing and Re-Credentialing due to a Program Integrity Issue, Suspensions and Terminations	Notification: Same Day
CM-21	Summary Report of Failed Provider Enrollment, Credentialing and Re-Credentialing due to a Program Integrity Issue, Suspensions and Terminations	Annual
CM-22	MCO Organization and Key Personnel Changes	Ad-Hoc
CM-23	Notification of Termination of Material Subcontractor	Notification: Same Day
CM-24	Notification Procurement and Re-Procurement of Material Subcontractor (60 days prior)	Ad-Hoc
CM-25	Material Subcontractor List Annual Summary	Annual
CM-26	Coordination of Benefits / Third Party Liability Report (Appendix I) a. Third Party Health Insurance Cost Avoidance Claims Amount by Carrier b. Third Party Health Insurance Total Recovery Savings by Carrier c. Accident Trauma Recoveries d. Accident/Trauma Cost Avoidance	Semi-Annual
CM-27	Third Party Liability Indicator Form (Appendix I)	Notification: Same Day
CM-28	Benefits Coordination Structure (Appendix I)	Ad-Hoc
CM-29	Encounter Data Submission (Appendix E)	Monthly
CM-30	Sampling of Enrollees To Ensure Services Received Were The Same As Providers Billed	Annual
CM-31	Notification of Federally Required Disclosures (in accordance with Section 6.1.O and as specified in Appendix L)	Ad-Hoc
CM-32	Notification of Reportable Findings /Network FRD	Notification: Same Day

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
CM-33	Summary of Reportable Findings/Network FRD Forms	Annual
CM-34	Notification of Provider Overpayments	Ad-Hoc
CM-35	Summary of Provider Overpayments	Annual
CM-36	Provider Materials (related to enrollee cost-sharing, changes to Covered Services and/or any other significant changes per contractual requirements)	Ad-Hoc
CM-37	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
CM-38	Enrollees enrolled in an MCO's Controlled Substance Management Program upon date of termination.	Monthly
CM-39	PCP/Enrollee assignment report	Monthly
CM-40	PCP/Enrollee assignment report	Ad-hoc
CM-41	Excluded Provider Monitoring Report	Monthly
CM-42	Utilization Management Reports	TBD
CM-43	MCO Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annual and Ad Hoc

C. Quality Reporting

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
Q-1	Quality Improvement Goals (Appendix B) (Includes QM/QI Work plan and Summary List of Enrollees with No Service Utilization)	Appendix B Reporting Timeline
Q-2	Enrollee and Provider Incentives Notification	Ad-Hoc
Q-3	CAHPS Report (Submission of full CAHPS Report)	Annual
Q-4	External Research Project Notification	Ad-Hoc
Q-5	External Audit/Accreditation	Ad-Hoc
Q-6	HEDIS IDSS	Annual

D. Behavioral Health Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
BH-1	Behavioral Health Reportable Adverse Incidents and Roster of Reportable Adverse Incidents-Daily Incident Delivery Report	Notification: Same Day
BH-2	Behavioral Health Adverse Incident Summary Report	Annual
BH-3	Behavioral Health Readmission Rates	Annual
BH-4	Behavioral Health Ambulatory Continuing Care Rates	Annual
BH-5	Inpatient/CBAT Cases Awaiting Resolution and Discharge (CARD) Census Report	Monthly
BH-7	Use of CANS During Diagnostic Evaluations	Monthly
BH-9	Intensive Care Coordination Claims-Based Indicators	Monthly
BH-10	CBHI Cost and Utilization Reports Based on paid claims or Intensive Home and Community Based Services for Youth and Youth Mobile Crisis Intervention Services	Monthly
BH-11	Behavioral Health Medical Records Review Report	Annual
BH-12	Annual Submission of (updated) Behavioral Health Performance Specifications and Clinical Criteria	Annual
BH-13	Behavioral Health Clinical Operations/Inpatient & Acute Service Authorization, Diversions, Modification and Denial Report	Quarterly
BH-14	Psychotropic Drugs Report	Quarterly
BH-15	Behavioral Health Utilization and Cost Report	Quarterly
BH-17	Department of Mental Health (DMH) Daily Admissions	Notification: Same Day
BH-18	Behavioral Health Provider Network Access and Availability	Annual
BH-19	Behavioral Health Telephone Statistics	Annual
BH-20	Behavioral Health Significant Changes in Provider Network Notification	Notification: Same Day

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
BH-21	Behavioral Health Intensive Clinical Management Referrals	Semi-Annual
BH-22	Behavioral Health Inquiries, Grievances, Internal Appeals and BOH	Annual
BH-24	CANS Compliance. This report is required when CANS data is made available through the Virtual Gateway to the MCO.	Quarterly
BH-25	Behavioral Health Mobile Crisis Intervention Length of Stay Report	Quarterly
BH-26	Members Boarding in Emergency Departments or on Administratively Necessary Days (AND) Status	Daily

E. Financial Reports

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
F-1	Notification to EHS Regarding Negative Change in Financial Status	Notification: Same Day
F-2	Outstanding Litigation Summary	Annual
F-3	Financial Ratio Analysis	Annual
F-4	MCO Experience Review and Revenue Expense Report	Quarterly
F-5	MCO Experience Review and Utilization/Cost Reports	Quarterly
F-7	Liability Protection Policies	Annual
F-8	DOI Financial Report (for Plans that are DOI licensed)	Quarterly
F-9	Insolvency Reserves	Annual
F-10	Lag Triangles and Completion Factors Report (IBNR)	Quarterly
F-11	Description of Incurred But Not Reported (IBNR) Methodology	Annual
F-12	Audited Financial Statements	Annual
F-13	Attestation Report from Independent Auditors on Effectiveness of Internal Controls	Annual
F-14	Financial Relationships Report	Annual
F-15	Annual Administrative Detail Report	Annual
F-17	Annual Risk Share Report	Annual
F-18	Report on Acute Hospitals Paid Higher Rates than MassHealth, SPAD, PAPE or Transfer Per Diem	Ad-Hoc
F-19	Report on Rates Paid to a Parent Organization or Subsidiary in the Previous Contract Year	Ad-Hoc
F-22	CBHI Reconciliation Report	Annual
F-30	ABA Reconciliation Report	Annual
F-23	Ad Hoc Cash Flow Statement	Ad-Hoc
F-24	Any Default of the Contractor's Obligations 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: Same Day
F-25	Significant Organizational Changes, New Material Subcontractors, or Potential Business Ventures That May Impact Performance	No later than 30 days prior to execution

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
F-26	Provider Risk Arrangements	Ad-Hoc
F-27	Changes in Contractor's Providers' Risk Arrangements	Notification: Same Day
F-28	Working Capital Requirement Notification ("if" working capital falls below 75% below the amount reported on the prior year audited financial reports)	Two Business Days
F-29	Continuing Services Reconciliation Data	Ad-Hoc
F-31	Medical Loss Ratio (MLR) Report	Annually

F. Operations

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
O-1	Inbound-Daily-Demographic Change File Interface to MMIS per Appendix K	Notification: Same Day
O-2	Inbound Pharmacy Co-pay Interface to MMIS per Appendix K	Notification: Same Day
O-3	HIPPA 834 History Request	Ad-Hoc
O-4	Long-term Care Report Log	Weekly
O-6	Inbound Managed Care Provider Directory Interface	Monthly
O-7	Member Discrepancy Report	Monthly
O-8	Blank Rate Cell Report	Ad-Hoc

G. Pharmacy

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
PHM-1	MCO Pharmacy Claims Level Interface-Version 1: 6-8-10 (NCPDP Post-Adjudication Standard Version 2.1. – History View) and MCO Pharmacy Claims Level Interface Change Control Doc Version 1.3	Monthly
PHM-2	MassHealth Custom Interface Guide - 837 Medication Claims - Paid Claims File Layout for Batch Interface to Pharmacy Systems for Federal Drug Rebate	Monthly
PHM-3	MCO Pharmacy Provider Network Identification Layout (per Appendix P)	Monthly
PHM-4	MCO/PBM00 MassHealth Drug Rebate File Submission Report for the MCOs to self- report monthly on the submission of Drug Rebate files to the POPS Portal according to the schedule published by EOHHS (per Appendix P)	Monthly

MCO Contract Exhibit Number	Name of Report	Deliverable Frequency
PHM-5	Drug Utilization Review Report	Monthly
PHM-6	MCO Registration Form for Access to the MassHealth Drug Rebate Portal	Ad-Hoc
PHM-7	MCO Pharmacy Retail Registration Form for Access to the MassHealth Drug Rebate Portal	Ad-Hoc

APPENDIX B
Quality Improvement Goals

1. INTRODUCTION

This appendix describes the requirements for the Quality Improvement Goals as specified in **Section 2.13** of the Contract. The QI Goals measurement cycle spans a 3-year period which includes planning/baseline, mid-cycle, and final evaluations to allow for tracking of improvement gains. For each QI goal cycle (3-year period), EOHHS will establish a series of QI goal domains as well as approve and/or designate measurement and quality improvement activities. QI Goal domains are selected based on three priority areas for improving quality and health outcomes developed by the Department of Health and Human Services Public Health Quality Forum

- Impact: The extent of significant improvements in population health, health equity, quality, and safety that could result from changes in this area
- Improvability: The potential for changes that could lead to desired health, process, or system outcomes
- Practice variability: The potential for standardizing areas where wide variability in practice exists and where gaps between current practices and knowledge can be closed without hindering innovation.

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

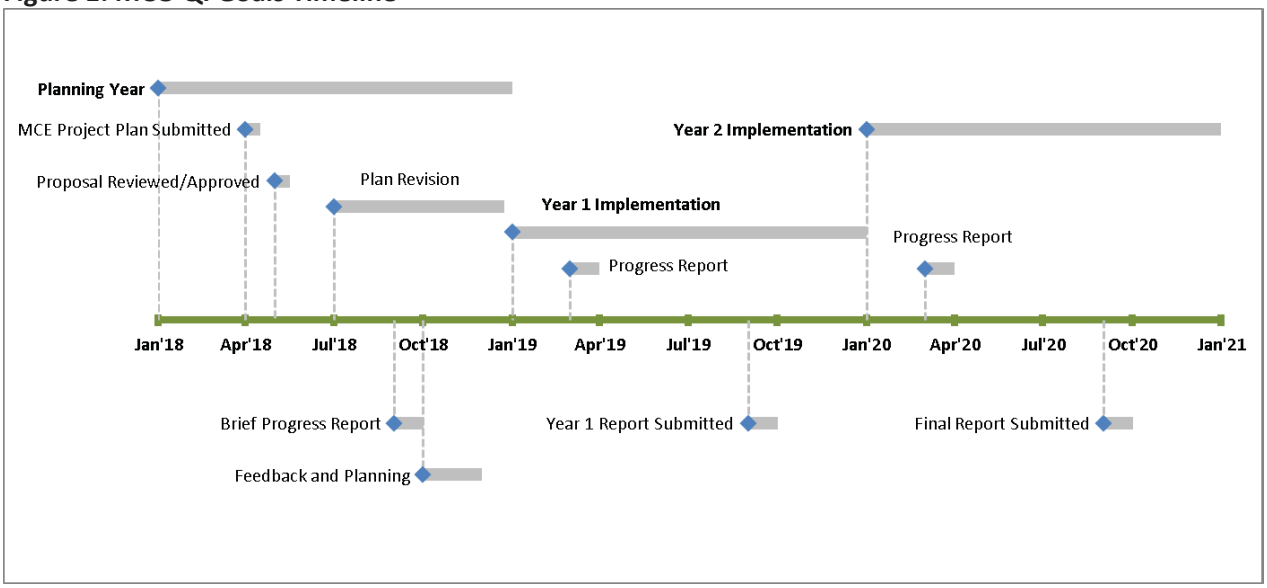
2. QI IMPLEMENATION DETALS

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

TABLE 1: QI GOAL IMPLEMENTATION PERIODS AND ASSOCIATED ACTIVITIES	
Cycle 1: January 1, 2018 – December 31, 2020	
Baseline/Initial Implementation Period: January 1, 2018 – December 31, 2018	• *Planning Phase*: *January- April 2018* MCOs engage in detailed project planning in an effort to develop a data-driven, evidence-based plan for interventions using quality improvement principles. Tasks include but are not limited to the development of a problem statement, a review of evidence-based literature, and interventions to address the problem, and completion of quality improvement tools and activities that support project planning including root causes analyses, barrier analyses, development of driver diagrams, population analyses. • *Quality Improvement Plan Submission: May 2018* MCOs submit QI proposals to the MassHealth or its designee for review and approval. Proposals will describe planned activities and data collection plans for initial implementation. • *Initial Implementation: June 2018-December 2018*

	MCOs modify QI plans for year 1 based on feedback received from EOHHS. MCEs may focus on developing stakeholder engagement, process mapping and implementation of small test of change to inform initial Implementation. **In September 2018,** MCEs submit brief progress report detailing **baseline year data (CY 2017)**, description of activities currently underway, and plans for Mid-cycle Implementation.
Mid-cycle Implementation Period: Calendar Year 18 (January 1, 2019 – December 31, 2019)	• *Mid-Cycle Launch: January 2019* MCEs implement Mid-cycle interventions and collect data on short-term indicators. • *Mid-Cycle Progress Reports*: *March 2019* MCEs submit Progress reports detailing changes made as a result of feedback or lessons learned in the previous cycle. Plans will provide updates on the current year's interventions and identify challenges for discussion and problem-solving with EOHHS or its designee. • *Mid-Cycle Annual Report: September 2019* MCEs submit annual reports describing current interventions, report on short-term indicators, HEDIS data as applicable, and assess results including success and challenges. Reports will also include plans for final implementation period modifications.
Final Implementation Period: Calendar Year 19 (January 1, 2020 – December 31, 2020)	• *Final Implementation Launch: January 2020* MCEs implement Mid-cycle interventions and collect data on short-term indicators. • *Final Implementation Progress Reports*: *March 2020* MCEs submit Progress reports detailing changes made as a result of feedback or lessons learned in the previous cycle. Plans will provide updates on the current year's interventions and identify challenges for discussion and problem-solving with EOHHS or their designee. • *Final Implementation Annual Report: September 2020* MCEs submit annual reports describing current interventions, report on short-term indicators, HEDIS data as applicable, and assess results including success and challenges. Reports will also include plans for the final quarter of QI activities.

Figure 1: MCO QI Goals Timeline



QI goal cycle 2 will begin January 1, 2021 and conclude December 31, 2023. The activities associated with Cycle 2 will mirror those outlined for Cycle 1. However, QI Goal activities, requirements, and domains are subject to changed given EOHHS needs and priorities.

3. MCO QI DOMAIN AREAS AND GOALS: CYCLE 1, January 1, 2018 – December 31, 2020

Domain descriptions and specific goals are outlined in Table 2: Domain Areas and Goals.

Table 2: Domain Areas and Goals	
Domain I: Wellness and Health Promotion - Maintaining member health as to avoid health problems in the future.	
Goals:	• To increase the use of primary care services. • To improve the early detection of chronic health problems through preventive screenings and assessments.
Domain 2: Behavioral Health - Promoting well-being through prevention and treatment of mental illness including substance use and other dependencies.	
Goals:	• To increase the delivery of behavioral health services. • Achieve better behavioral health outcomes. • Improve the overall behavioral health of the plan's population, especially those with mental illness and substance abuse.
Domain 3: Chronic Disease Management: - Providing services and assistance to Enrollees with or at risk for specific diseases and/or conditions.	
Goals:	• To identify members at risk for one or more chronic conditions and

	address risk factors that contribute to disease. • To improve the quality of life for members with one or more chronic conditions through self-management and adherence to treatment.
Domain 4: Population and Community Needs Assessment and Risk Stratification - Identifying and assessing priority populations for health conditions and determinant factors with the most significant size and impact and developing interventions to address the appropriate and timely care of these priority populations.	
Goals:	• To support the implementation of the Population and Community Needs Assessment and Risk Stratification contract requirements as stated in Section 2.5.H.1 of Attachment A (Model Contract).

4. Domain Measures and Interventions:

Specific measures and interventions will be determined during the submission and review of the MCO's Quality Improvement Plan.

5. MCO Reports, Submissions, and Templates:

Participating MCOs will submit to MassHealth or its designee:

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

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

MCOs will submit Quality Improvement Plans and Reports using the QI Goals Submission Templates developed and distributed by EOHHS on or before January 30, 2018. Additionally, MCOs will submit data on all quality metrics included in Exhibit 1 of this document. MCOs are required to submit their IDSS table for all HEDIS quality metrics. For non-HEDIS measures, MCOs will report the data using the QI Goals submission data tables which will be distributed by EOHHS on or before January 30, 2018.

QI Goal Reporting submissions shall include quantitative and qualitative data as well as specific progress made to each measure, barriers encountered, lessons learned, and planned next steps. For specific instructions on the submission process and detail on the submission templates, MCOs shall refer to the Submission Guide to be on distributed on or before January 30, 2018.

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

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

QM/QI Work Plan: MCOs will submit their annual QM/QI Work Plan. The Work Plan must include the components outlined in the MCO Contract (Section 2.13).

Evaluation of QI Reports: EOHHS or its designee will review QI Goal Reports and Work Plans using a standardized Evaluation Template. The scoring elements in the Evaluation Template will correspond directly with the elements documented on the reporting templates. Feedback will be provided to the MCOs for each implementation period.

Cultural Competency

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

Appendix B
Exhibit 1: Quality Measures

EOHHS has defined the following quality measures pursuant to **Section 2.13.C.6** of the Contract. For measures that are not HEDIS, EOHHS will further define measure specifications, including due dates, sample size, and submission requirements. This list is subject to modifications.

	Measure Name	NQF_ID	Set	Domain
1	**Adherence to antipsychotic medications for individuals with schizophrenia (SAA)**	1879	HEDIS	Behavioral Health and Substance Abuse
2	**Adolescent well-care visit (AWC)**	NA	HEDIS	Screening and Prevention
3	**Adult BMI Assessment (ABA)**	NA	HEDIS	Screening and Prevention
4	**Adults' access to preventive/ambulatory health services (AAP)**	NA	HEDIS	Patient Centeredness
5	**All cause readmission amount LTSS CP eligible**	NA	MA Specific	Integration
6	**All condition Readmission**	NA		Avoidable Utilization
7	**Ambulatory care (AMB)**	NA	HEDIS	Affordability
8	**Ambulatory Care (ED Visits): The rate of ED visits per 1,000 member months (AMB)**	NA	HEDIS	Outcomes
9	**Annual monitoring for patients on persistent medications (MPM)**	2371	HEDIS	Patient Safety
10	**Antibiotic utilization (ABX)**	NA	HEDIS	Affordability
11	**Antidepressant Medication Management (AMM)**	0105	HEDIS	Behavioral Health and Substance Abuse
12	**Appropriate testing for children with pharyngitis (AWP)**	0002	HEDIS	Appropriate Acute Care
13	**Appropriate treatment for children with upper respiratory infection (URI)**	0069	HEDIS	Appropriate Acute Care
14	**Arthritis: disease modifying antirheumatic drug (DMARD) therapy in rheumatoid arthritis (ART)**	0054	HEDIS	At Risk Populations
15	**Assessment for LTSS**	N/A		Long Term Supports and Services
16	**Asthma Medication Ratio (AMR)**	1800	HEDIS	At Risk Populations
17	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)**	0058	HEDIS	Appropriate Acute Care
18	**Breast Cancer Screening (BCS)**	2372	HEDIS	Screening and Prevention
19	**CAHPS Health Plan Survey v 5.0 (including any supplemental questions)**	0006	CAHPS - Health Plan	Patient Centeredness
20	**CAHPS: Flu Vaccinations for Adults Ages 18 and Older**	0039	CAHPS - Health Plan	Screening and Prevention

	Measure Name	NQF_ID	Set	Domain
21	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia		HEDIS	
22	Care management plan for high risk patients	NA	PCMHI	Care Management
23	Care Plans within 90 days of enrollment	NA	MA Specific	Care Management
24	Cervical cancer screening (CCS)	0032	HEDIS	Screening and Prevention
25	Childhood immunization status (CIS)	0038	HEDIS	Screening and Prevention
26	Children and adolescents' access to PCPs (CAP)	NA	HEDIS	Patient Centeredness
27	Chlamydia screening in women (CHL)	0033	HEDIS	Screening and Prevention
28	Colorectal Cancer Screening (COL)	0034	HEDIS	Screening and Prevention
29	Comprehensive diabetes care: High blood pressure control (CDC)	0061	HEDIS	At Risk Populations
30	Comprehensive diabetes care: Urine screening for microalbumin or evidence of nephropathy (CDC)	0062	HEDIS	At Risk Populations
31	Comprehensive diabetes care: A1c poor control (CDC)	0059	HEDIS	At Risk Populations
32	Comprehensive diabetes care: A1c testing (CDC)	0057	HEDIS	At Risk Populations
33	Comprehensive diabetes care: Dilated eye exam in diabetic patient (CDC)	0055	HEDIS	At Risk Populations
34	Comprehensive diabetes care: Foot exam (CDC)	0056	HEDIS	At Risk Populations
35	Comprehensive diabetes care: HbA1c control (<8.0%) (CDC)	0575	HEDIS	At Risk Populations
36	Controlling high blood pressure (CBP)	0018	HEDIS	At Risk Populations
37	Diabetes monitoring for people with diabetes and schizophrenia (SMD)	1934	HEDIS	Behavioral Health and Substance Abuse
38	Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	1932	HEDIS	Behavioral Health and Substance Abuse
39	Emergency Department Boarding for SMI/SED/SUD Population	NA	MA Specific	Integration
40	Emergency Department utilization for SMI/SED/SUD population	NA	MA Specific	Integration
41	Follow-Up After Hospitalization for Mental Illness (FUH)	0576	HEDIS	Behavioral Health and Substance Abuse
42	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	0108	HEDIS	Behavioral Health and Substance Abuse

	Measure Name	NQF_ID	Set	Domain
43	**Frequency of ongoing prenatal care (FPC)**	1391	HEDIS	Maternal/Newborn Care
44	**Frequency of selected procedures (FSP)**	NA	HEDIS	Affordability
45	**High Blood Pressure Screening and Follow-up for People with SMI or AOD**	2602		Behavioral Health and Substance Abuse
46	**Hospital Admission for SME/SED/SUD population**	NA	MA Specific	Integration
47	**Identification of Alcohol and Other Drug Services (IAD)**	NA	HEDIS	Behavioral Health and Substance Abuse
48	**Immunizations for Adolescents (IMA)**	1407	HEDIS	Screening and Prevention
49	**Initiation and Engagement of AOD Treatment (IET)**	0004	HEDIS	Behavioral Health and Substance Abuse
50	**Inpatient Utilization (IPU)**	NA	HEDIS	Affordability
51	**Lead Screening in Children (LSC)**		HEDIS	Screening and Prevention
52	**Medication Management for People with Asthma (MMA)**	1799	HEDIS	At Risk Populations
53	**Member Satisfaction Survey**	N/A		
54	**Mental Health Utilization (MPT)**	NA	HEDIS	Behavioral Health and Substance Abuse
55	**Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)**	NA	HEDIS	Behavioral Health and Substance Abuse
56	**Non-recommended Cervical Cancer Screening in Adolescent Females**	N/A	HEDIS	Effectiveness of Care
57	**Persistence of Beta-Blocker Treatment after Heart Attack (PBH)**	0071	HEDIS	At Risk Populations
58	**Pharmacotherapy Management of COPD Exacerbation (PCE)**	0549	HEDIS	At Risk Populations
59	**PQI-15: Asthma Admission Rate**	0283	Prevention Quality Indicators (PQI)	Ambulatory Sensitive Conditions
60	**Prenatal & Postpartum Care (PPC)**	1517	HEDIS	Maternal/Newborn Care
61	**Provider satisfaction survey**	NA		
62	**Statin Therapy for Patients with Cardiovascular Disease**	NA	HEDIS	At Risk Populations
63	**Statin Therapy for Patients with Diabetes**	NA	HEDIS	At Risk Populations
64	**Tobacco use assessment and tobacco cessation intervention**	0028	Substance Use (SUB)	Screening and Prevention

	Measure Name	NQF_ID	Set	Domain
65	**Transition Record with Specified Elements Received by Discharged Patients**	0647	Care Transitions	Care Coordination & Transitions
66	**Use of appropriate medications for people with asthma (ASM)**	0036	HEDIS	At Risk Populations
67	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)**	NA	HEDIS	Behavioral Health and Substance Abuse
68	**Use of imaging studies for Low Back Pain (LBP)**	0052	HEDIS	Affordability
69	**Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)**	NA	HEDIS	Behavioral Health and Substance Abuse
70	**Use of spirometry testing in the assessment and diagnosis of COPD (SPR)**	0577	HEDIS	At Risk Populations
71	**Utilization of behavioral health community partner care coordination services**	NA	MA Specific	Integration
72	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**	0024	HEDIS	Screening and Prevention
73	**Well child visits in the first 15 months of life (W15)**	1392	HEDIS	Screening and Prevention
74	**Well child visits in the third, fourth, fifth and sixth years of life (W34)**	1516	HEDIS	Screening and Prevention

Appendix B
Exhibit 2: Key Quality Performance Measures

This Exhibit summarizes the key performance measures identified by EOHHS. In accordance with **Section 2.13.C.6** of the Contract, 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. Additionally, key performance measures are subject to modification as directed by EOHHS and do not reflect a comprehensive list of Contract requirements under this Contract. EOHHS shall notify the Contractor of any updates to the exhibits or thresholds.

	Contract section	Metric	Compliance threshold	Reporting	Frequency
1	2.13.C.6	All condition readmission rate	TBD, tracking in year 1	TBD	Quarterly
2	2.13.C.1.c.3	Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Overall plan rating TBD	CAHPS Report (Submission of full CAHPS Report)	Annually
3	2.13.C.1.a.1	Well child visits in the first 15 months of life (W15)	Meet or exceed the 90th Medicaid Percentile.	HEDIS	Annually
4	2.13.C.1.a.1	Well child visits in the third, fourth, fifth and sixth years of life	Meet or exceed the 90th Medicaid Percentile.	HEDIS	Annually
5	2.13.C.1.a.1	Adolescent well-care visit	Meet or exceed the 90th Medicaid Percentile.	HEDIS	Annually
6	2.13.C.1.a.1	Adults' access to preventive ambulatory health services	Meet or exceed the 75th Medicaid Percentile.	HEDIS	Annually

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 – to expectant and new mothers 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.	✓	✓	✓	✓
Chiropractic Services – The Contractor is responsible for providing chiropractic	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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 or Rehabilitation Hospital Services – services, for all levels of care, provided at either a 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. The Contractor shall use the following MassHealth admission/coverage criteria for admission into a chronic hospital or rehabilitation hospital, and may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts the 100-day limitation at either a chronic or rehabilitation hospital for that Contract Year. For the applicable criteria, see 130 CMR 435.408, 435.409 and 435.410 (rehabilitation hospitals).		✓		
Chronic, Rehabilitation Hospital or Skilled Nursing Facility Services – services, for all levels of care, 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 skilled 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 the 100-day limitation at either a nursing facility, chronic or rehabilitation hospital for that Contract Year. For the applicable criteria, see 130 CMR 456.408, 456.409, 456.410 and 435.408, 435.409 and 435.410 (rehabilitation hospitals). 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.	✓		✓	✓
Dental - Emergency related dental services as described under Emergency Services in **Appendix C, Exhibit 1** and oral surgery performed in an outpatient setting, as described in	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Ambulatory Surgery/Outpatient Hospital Care in **Appendix C, Exhibit 1**, which is Medically Necessary to treat a medical condition.				
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 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.	✓			✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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 age 3 or under.	✓	✓		✓
Emergency Services – covered inpatient and outpatient services, including Behavioral Health Services, that 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 up to age 3; however, the service is allowed for children up to age 21 in those instances where the Enrollee does not have access to a dentist and the service is Medically Necessary as determined by a Caries Assessment Tool (CAT).	✓	✓		✓
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.	✓	✓	✓	✓
Home Health Services –- services include: part-time or intermittent skilled nursing visits, physical therapy visits, occupational therapy visits, speech language therapy visits and home health aide services. In order to be eligible for Home Health aide services, the Enrollee must have a need for nursing services or therapy services. See CMR 403.000	✓	✓	✓	✓
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 aid services; medical supplies, drugs	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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 **Section 2.8.H.4**., including all medically necessary vaccines not covered by the Commonwealth of Massachusetts Department of Public Health.	✓	✓	✓	✓
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. For individuals over age 21, certain limitations apply. 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	✓	✓	✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
(IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental.				
Pharmacy – The Contractor is responsible for providing prescription and over-the-counter 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. 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 age 21 and over to those necessary for the life and safety of the Enrollee.	✓	✓	✓	✓
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				✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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	✓	✓	✓	✓
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.	✓	✓	✓	✓
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.	✓	✓	✓	✓
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	✓		✓	✓

Service	Coverage Types			
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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.				
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.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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. 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.	✓			✓
Chapter 766 – home assessments and participation in team meetings.	✓	✓		✓
Chronic or Rehabilitation Hospital Services - services provided at either a chronic or rehabilitation hospital, or any combination thereof, over 100 days per Contract Year per Enrollee.		✓	✓	

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Chronic, Rehabilitation Hospital, or Skilled Nursing Facility Services - 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 for Enrollees receiving Hospice services, the Contractor shall cover skilled nursing facility services without limitation.	✓			✓
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 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.	✓			✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
Intensive Early Intervention Services - 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 Intervention Service Providers.	✓	✓		✓
Keep Teens Healthy - services provided pursuant to EOHHS's "Keep Teens Healthy" provider agreement.	✓	✓		✓
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.	✓			✓
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.	✓			
Residential Rehabilitation Services (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 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.	✓	✓	✓	
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.	✓	✓	✓	

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

	Coverage Types			
Service	**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)**				

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
1. **Inpatient Mental Health Services** - hospital services to evaluate and treat an acute psychiatric condition which 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or others; or 4) has resulted in marked psychosocial dysfunction or grave mental disability.	✓	✓	✓	✓
2. **Inpatient Substance Use Disorder Services (Level IV)** - hospital services that provide a detoxification regimen of medically directed evaluation, care and treatment for psychoactive substance-abusing Enrollees in a medically managed setting.	✓	✓	✓	✓
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.	✓	✓	✓	✓
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. **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	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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. **Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7)** – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; 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.	✓	✓	✓	✓
d. **Clinical Support Services for Substance Use Disorders (Level III.5)** – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; 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	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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.				
Non-24-Hour Diversionary Services				
a. **Community Support Program (CSP)** - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Enrollees with a long standing history of a psychiatric or substance use disorder and to their families, or to Enrollees who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.	✓	✓	✓	✓
b. Partial Hospitalization (PHP) – an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available five to 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.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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 from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.	✓	✓	✓	✓
f. **Recovery Coaching** - a non-clinical service provided by peers with lived Substance Use Disorder experience who have been certified as Recovery Coaches. Eligible Enrollees will be connected with Recovery Coaches at critical junctures in the Enrollees' treatment and recovery. Recovery Coaches meet with Enrollees and 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, doing outreach and building relationships with individuals in programs, including detoxification 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	✓	✓	✓	

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
treatment and staying motivated for treatment and recovery.				
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	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
disorders if the Contractor determines that, based on available research, DBT is effective and meets the Contractor's criteria for determining medical necessity.				
e. **Psychiatric Consultation on an Inpatient Medical Unit** - an in- person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and an Enrollee at the request of the medical unit to assess the Enrollee's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.	✓	✓	✓	✓
f. **Medication Visit** - an individual visit specifically for psychopharmacological evaluation, prescription, review, and/or monitoring by a psychiatrist or R.N. Clinical Specialist for efficacy and side effects.	✓	✓	✓	✓
g. **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.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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.	✓	✓		✓
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 Replacement Therapy** - medically monitored administration of methadone, Buprenorphine , or other U.S. Food and Drug Administration (FDA)-approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
o. **Ambulatory Detoxification (Level II.d)** - outpatient services for Members who are experiencing a serious episode of excessive substance use or withdrawal complications. Ambulatory Detoxification 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 a Covered Individual's cognitive, emotional, neuropsychological, verbal, and defensive functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing.	✓	✓	✓	✓
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.	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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 interventions, including a crisis-response strategy, that are incorporated into the child's	✓			✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
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	✓	✓		✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the treatment plan designed to address the child's mental health and emotional challenges. This service includes teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations, and to assist the family in supporting the child in addressing his or her emotional and mental health needs. Phone contact and consultation may be provided as part of the intervention.				
e. Therapeutic Mentoring Services: This service provides a structured, one-to-one mentoring relationship between a therapeutic mentor and a child or adolescent for the purpose of addressing daily living, social and communication needs. Each child or adolescent will have goals and objectives that are designed to support age-appropriate social functioning or ameliorate deficits in the child or adolescent's age-appropriate social functioning. These goals and objectives are developed by the child or adolescent, as appropriate, and his/her treatment team and are incorporated into the treatment plan. The service includes supporting, coaching and training the child or adolescent in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution and relating appropriately to other children and adolescents, as well as adults, in recreational and social activities. The therapeutic mentor works with the child or adolescent in such settings as their home, school or social or recreational activities.	✓			✓
Emergency Services Program (ESP) - services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. **(See detailed services below)**				
1. ESP Encounter - each 24-hour period an individual is receiving ESP Services. Each ESP Encounter shall include at a minimum: crisis assessment, intervention and stabilization. **a. Assessment -** a face-to-face evaluation of an individual presenting with a	✓	✓	✓	✓

Service	Coverage Types			
	MCO MassHealth Standard & CommonHealth Enrollees	MCO MassHealth Family Assistance Enrollees	CarePlus	Special Kids Special Care
behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel; **b. Intervention –the** provision of psychotherapeutic and crisis counseling services to an individual for the purpose of stabilizing an emergency; and **c. Stabilization –** short-term behavioral health treatment in a structured environment with continuous observation and supervision of individuals who do not require hospital level of care. In addition, medication evaluation and specialing services shall be provided if Medically Necessary.				
2. Youth Mobile Crisis Intervention: a short term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, 7 days a week.	✓	✓		✓
Other Behavioral Health Services - Behavioral Health Services that may be provided as part of treatment in more than one setting type.				
1. Electro-Convulsive Therapy (ECT) - a therapeutic service which initiates seizure activity with an electric impulse while the individual is under anesthesia. It is administered in a facility that is licensed to provide this service by DMH.	✓	✓	✓	✓
2. Specialing - therapeutic services provided to an Enrollee in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.	✓	✓	✓	✓

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
   c. Services provided to newborns during the period prior to notification by EOHHS of retroactive enrollment of the newborn as provided in **Section 2.4.C.**

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

APPENDIX D, EXHIBIT 1
BASE CAPITATION RATES
Contract Year 1

Listed below are the Per Member Per Month (PMPM) Base Capitation Rates for Contract Year 1 (March 1, 2018 through December 31, 2018) (also referred to as Rate Year 2018 or RY18), subject to state appropriation and all necessary federal approvals.

Base Capitation Rates do not include EOHHS adjustments described in **Sections 4.2.C** and **4.2.E**. of the Contract.

In addition to the Base Capitation Rates tables below, additional tables include the add-ons for CBHI as described in **Section 4.5.D** and the add-ons for ABA Services as described in **Section 4.5.E**. The add-ons for CBHI and ABA 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 March 1, 2018 – December 31, 2018 (RY 18)					
REGION	**NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)**	**HCV COMPONENT (per member per month)**	**NON-HCV HIGH COST DRUG COMPONENT (per member per month)**	**ADMINISTRATIVE COMPONENT (per member per month)**	**TOTAL BASE CAPITATION RATE (per member per month)**
Northern	**$429.32**	**$15.40**	**$1.45**	**$37.17**	**$483.34**
Greater Boston	**$449.62**	**$14.51**	**$1.78**	**$38.54**	**$504.45**
Southern	**$471.64**	**$18.54**	**$2.82**	**$38.89**	**$531.89**
Central	**$439.16**	**$13.48**	**$0.76**	**$37.51**	**$490.91**
Western	**$386.28**	**$11.40**	**$2.75**	**$27.41**	**$427.84**

MCO Base Capitation Rates / RC I Child					
Effective March 1, 2018 – December 31, 2018 (RY 18)					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$177.86	$0.11	$2.28	$22.49	$202.74
Greater Boston	$191.72	$0.10	$2.99	$23.47	$218.28
Southern	$187.21	$0.14	$1.49	$22.77	$211.61
Central	$183.21	$0.10	$2.06	$22.67	$208.04
Western	$191.83	$0.09	$1.99	$19.96	$213.87

MCO Base Capitation Rates / RC II Adult					
March 1, 2018 – December 31, 2018 (RY 18)					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,536.45	$80.94	$12.09	$100.65	$1,730.13
Greater Boston	$1,564.03	$86.42	$8.40	$100.14	$1,758.99
Southern	$1,523.67	$81.95	$21.16	$95.69	$1,722.47
Central	$1,461.71	$57.01	$12.05	$92.70	$1,623.47
Western	$1,275.61	$60.95	$3.13	$58.90	$1,398.59

MCO Base Capitation Rates / RC II Child					
March 1, 2018 – December 31, 2018 (RY 18)					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$847.79	$0.91	$53.95	$58.90	$961.55
Greater Boston	$897.91	$1.15	$68.11	$60.82	$1,027.99
Southern	$824.37	$1.01	$46.58	$58.90	$930.86
Central	$814.25	$0.62	$47.87	$58.90	$921.64
Western	$608.45	$0.55	$23.16	$58.90	$691.06

MCO Base Capitation Rates / RC IX					
March 1, 2018 – December 31, 2018 (RY 18)					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$426.03	$25.81	$8.17	$34.02	$494.03
Greater Boston	$386.28	$25.62	$4.71	$32.34	$448.95
Southern	$481.86	$29.47	$2.32	$36.09	$549.74
Central	$454.33	$23.25	$6.58	$35.27	$519.43
Western	$332.47	$25.10	$2.83	$29.52	$389.92

MCO Base Capitation Rates / RC X					
March 1, 2018 – December 31, 2018 (RY 18)					
REGION	NON-HIGH COST DRUG / NON-HCV MEDICAL COMPONENT (per member per month)	HCV COMPONENT (per member per month)	NON-HCV HIGH COST DRUG COMPONENT (per member per month)	ADMINISTRATIVE COMPONENT (per member per month)	TOTAL BASE CAPITATION RATE (per member per month)
Northern	$1,331.98	$256.59	$1.09	$90.38	$1,680.04
Greater Boston	$1,151.89	$147.26	$1.56	$76.93	$1,377.64
Southern	$1,424.71	$202.31	$0.30	$91.30	$1,718.62
Central	$1,414.98	$198.53	$0.30	$93.21	$1,707.02
Western	$1,067.88	$107.48	$0.69	$72.26	$1,248.31

CBHI Add-On to Risk Adjusted Capitation Rates
Effective March 1, 2018 – December 31, 2018 (RY 18)

CBHI Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	$24.20
RC-II Child	$156.05

ABA Add-On to Risk Adjusted Capitation Rates
Effective March 1, 2018 – December 31, 2018 (RY 18)

ABA Add-On to Risk Adjusted Capitation Rates PMPM	
RC-I Child	$2.78
RC-II Child	$57.90

APPENDIX D, EXHIBIT 2
ADJUSTMENTS OR ADDITIONS TO PAYMENTS

Tables below include the Supplemental Maternity Payment per Delivery Event as described in **Section 4.3.B** and the Supplemental Specialized Inpatient Psychiatric Services Payment as described in **Sections 2.7.D.8** and **4.3.C**.

Supplemental Maternity Payment All Rating Categories	
March 1, 2018- December 31, 2018 (RY 18)	
Region	**Supplemental Payment per Delivery Event**
Northern	**$6,889.12**
Greater Boston	**$7,485.04**
Southern	**$7,359.66**
Central	**$6,982.80**
Western	**$6,498.40**

Supplemental Specialized Inpatient Psychiatric Services Payment	
March 1, 2018- December 31, 2018 (RY 18)	
Region	**Supplemental Payment Per Inpatient Day**
Northern	**$600.00**
Greater Boston	**$600.00**
Southern	**$600.00**
Central	**$600.00**
Western	**$600.00**

APPENDIX D, EXHIBIT 3
RISK SHARING ARRANGEMENTS

Contract-Wide Risk Sharing Arrangement (Section 4.5.C)

For the purposes of this **Appendix D, Exhibit 2, Contract-Wide Risk Sharing Arrangement (Section 4.5.C)**, if the Contractor elects to participate in the Optional RCII Adult Risk Sharing Arrangement pursuant to **Section 4.5.H**, "Regions" shall exclude any Region selected by the Contractor for the Optional RCII Adult Risk Sharing Arrangement and "Rating Categories" shall exclude the RCII Adult Rating Category.

1. **Gain on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment**

The amount of the Gain on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual non-High Cost Drug / Non-HCV medical expenditures for MCO Covered Services for the Contract Year, if such actual expenditures are less than the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year. The Gain shall be calculated in aggregate across all Regions and Rating Categories served by the Contractor.

Gain	**MassHealth Share**	**Contractor Share**
Less than or equal to 3% of the Aggregate Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment	0%	100%
Greater than 3% of the Aggregate Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment	50%	50%

2. **Loss on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment**

The amount of the Loss on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual non-High Cost Drug / Non-HCV medical expenditures for MCO Covered Services for the Contract Year, if such actual expenditures are greater than the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year. The Loss shall be calculated in aggregate across all Regions and Rating Categories served by the Contractor.

Loss	**MassHealth Share**	**Contractor Share**
Less than or equal to 3% of the Aggregate Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment	0%	100%
Greater than 3% of the Aggregate non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment	50%	50%

CBHI Services Risk Sharing Arrangement (Section 4.5.D)

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

   If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.D.1.a** is greater than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.D.1.b** then the Contractor shall be considered to have experienced a gain with respect to CBHI Services for the Contract Year. EOHHS and the Contractor shall share such gain in accordance with the table below:

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

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

   If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.D.1.a**, is less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.D.1.b**, then the Contractor shall be considered to have experienced a loss with respect to CBHI Services for the Contract Year. EOHHS and the Contractor shall share such loss in accordance with the table below:

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

ABA Services Risk Sharing Arrangement (Section 4.5.E)

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

   If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.E.1.a** above, is greater than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.E.1.b** above, then the Contractor shall be considered to have experienced a gain with respect to ABA Services for the Contract Year. EOHHS and the Contractor shall share such gain in accordance with the table below:

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

If the amount paid to the Contractor, as determined by the calculation described in **Section 4.5.E.1.a** above, is less than the Contractor's adjusted expenditures, as determined by the calculation described in **Section 4.5.E.1.b** above, then the Contractor shall be considered to have experienced a loss with respect to ABA Services for the Contract Year. EOHHS and the Contractor shall share such loss in accordance with the table below:

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

HCV Risk Sharing Arrangement (Section 4.5.F)

1. Gain on the HCV Medical Component of the Risk Adjusted Capitation Rate Payment

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

Gain	MassHealth Share	Contractor Share
Gain less than or equal to 5% of the HCV Medical Component of the Risk Adjusted Capitation Rate payment	0%	100%
Gain of more than 5% of the HCV Medical Component of the Risk Adjusted Capitation Rate payment	95%	5%

2. Loss on the HCV Medical Component of the Risk Adjusted Capitation Rate Payment

The amount of the Loss on the HCV Medical Component of the Risk Adjusted Capitation Rate Payment for

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

Loss	MassHealth Share	Contractor Share
Loss less than or equal to 5% of the HCV Component of the Risk Adjusted Capitation Rate payment	0%	100%
Loss of more than 5% of the HCV Component of the Risk Adjusted Capitation Rate payment	95%	5%

Non-HCV High Cost Drug Risk Sharing Arrangement (Section 4.5.G)

1. **Gain on the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment**

The amount of the Gain on the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual Non-HCV High Cost Drug expenditures for MCO Covered Services for the Contract Year, if such actual expenditures are less than the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year. The Gain shall be calculated in aggregate across all Regions and Rating Categories served by the Contractor.

Gain	MassHealth Share	Contractor Share
Gain less than or equal to 2% of the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate payment	0%	100%
Gain of more than 2% of the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate payment	100%	0%

2. **Loss on the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment**

The amount of the Loss on the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual

Non-HCV High Cost Drug expenditures for MCO Covered Services for the Contract Year, if such actual expenditures are greater than the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate Payment for the Contract Year. The Loss shall be calculated in aggregate across all Regions and Rating Categories served by the Contractor.

Loss	MassHealth Share	Contractor Share
Loss less than or equal to 2% of the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate payment	0%	100%
Loss of more than 2% of the Non-HCV High Cost Drug Component of the Risk Adjusted Capitation Rate payment	100%	0%

Optional RC II Adult Risk Sharing Arrangement (Section 4.5.H)

1. **Gain on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for Selected RC II Adult Regions**

   The amount of the Gain on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual non-High Cost Drug / Non-HCV medical expenditures for MCO Covered Services for the Contract Year, if such actual expenditures are less than the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year. The Gain shall be calculated for all Regions for which the Contractor elects the Optional RC II Adult Risk Sharing Arrangement (hereinafter "Selected RCII Adult Regions") and Rating Category II Adult (hereinafter "RCII Adult").

Gain	MassHealth Share	Contractor Share
Less than or equal to 1% of the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Selected RCII Adult Regions	0%	100%
Between 1% and 2% of the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Selected RCII Adult Regions	75%	25%
Greater than 2% of the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Selected RCII Adult Regions	90%	10%

2. **Loss on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for Selected RCII Adult Regions**

   The amount of the Loss on the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year shall be defined as the difference between the Non-High Cost

Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year and the Contractor's actual non-High Cost Drug / Non-HCV medical expenditures for MCO Covered Services for the Contract Year, if such actual expenditures are greater than the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Contract Year. The Loss shall be calculated for all Selected RCII Adult Regions.

Loss	**MassHealth Share**	**Contractor Share**
Less than or equal to 1% of the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Selected RCII Adult Regions	0%	100%
Between 1% and 2% of the Non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Selected RCII Adult Regions	75%	25%
Greater than 2% of the non-High Cost Drug / Non-HCV Medical Component of the Risk Adjusted Capitation Rate Payment for the Selected RCII Adult Regions	90%	10%

Encounter Data Set Request

Commonwealth of Massachusetts
MassHealth

October 1, 2017

Revision History

Date	Description	Author
01/11/2016	***I. In Additional Reference Data Set Elements (Section 3.4):*** Table *Services Data Set Elements* Added 5 new fields – MBHP specific. ***Additional Reference Data Layout (Section 4.5)*** Table *Services Data Set Layout* Added 5 new fields – MBHP specific. II. Added information about new BMC SCO to the list of all SCOs throughout the document. III. Replaced ICD-9-CM with ICD throughout the document.	**Alla Kamenetsky**
09/29/2015	**I.** ***In Data Elements Clarifications*** (***section 2.0):*** 1. Changed Inpatient Claim logic back to the old definition. **II**. ***In Encounter Data Set Elements (section 3.0):*** 1. Changed field #7 description back to "Filler". 2. "New Member ID" (field#76) - missing or invalid value in this field will be considered as a fatal error resulting in rejection of the record. **III.** ***In 3.1 Provider Data Set:*** 1. Edited ***File Processing*** section 2. Added a list of the fields that are 100% required to be complete with valid values on all the records. 3. Removed proposed "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). 4. Updated definition of "APCD ORG ID" (field#34) **IV**. ***In 4.0 Encounter Record Layout*** The length of "Recipient ZIP Code" (field#10) remains 5 N.	

Date	Description	Author
	V. ***In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks*** **Updated definitions of MassHealth Standards in**: -"Admission Date'' (field#15) -"Discharge Date''(field#16) -''Type of Admission" (field#24) -"Source of Admission" (field#25) -"Place of Service" (field#32) -"Patient Discharge Status" (field#34) -"Days Supply" (field#39) -"Refill Indicator" (field#40) -"Dispense as Written Indicator" (field#41) -"Admitting Diagnosis" (field#85) -"ICD Version Qualifier" (field#193)	
08/31/2015	**I. *In Data Elements Clarifications*** (section 2.0): 1. Added Capitation Payments clarification. 2. Updated Inpatient Claim clarification **II. *In Encounter Data Set Elements (section 3.0):*** 1. "Claim Category" (field #2) removed option "7 = Other (should be rarely used)" 1 2. Changed definition of "Plan Identifier" (field #4) o. 3. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator" 6.Updated definitions of : "Admission Date' (field#15) "Discharge Date" (field#16) "Type of Admission" (field#24) "Source of Admission"(field#25) "Procedure Code" (field #26), "Procedure Code Indicator" (field #30)"	**Rima Kayyali** **Alla Kamenetsky**

Date	Description	Author
	"Revenue Code" (field# 31) "Place of Service" (field # 32) "Place of Service Type" (field#33) "Patient Discharge Status" (field#34) "Quantity" (field#36) "NDC Number" (field# 37) "Metric Quantity" (field #38) "Dispense As Written Indicator" (field#41) "DRG" (field#72) "Prescribing Prov. ID" (field#81) "DRG Severity of Illness Level" (field#122) DRG Risk of Mortality Level" (field#123) **III. *in 3.2 Provider Data Set*:** 1, Added "File Processing" paragraph. 2. Updated definitions of: "Provider ID" (field#2) "Medicaid Number" (field#5) "Provider Last Name" (field#6) "Provider Fist Name" (field#7) "Provider Type" (field16) "Social Security Number" (field#28) "Tax ID Number" (field#30) Added two new fields: "APCD ORG ID" (field#34) and "Health Policy Commission Registered Provider Organization ID (RPO)" (field#35). **IV**. ***In 4.0 Encounter Record Layout*** 1. Replaced "Filler" (field #7) with "Header / Detail Claim Line Indicator". 2. Increased fields length: "Recipient ZIP Code" (field#10) from 5 N to 9 N; "Quantity" (field#36) from 5 N to 9 N; "Metric Quantity" (field#38) from 5N to 9 N **V**. **In 4.1 Provider Record Layout** 1. Increased fields length: "Provider Last Name" (Field # 6) from 30 C to 200 C "Provider Fist Name" (Field#7) from 30 C t0 100 C	

Date	Description	Author
	2. Added two new fields: “APCD ORG ID” (field 34) – 6 C “Health Policy Commission registered Provider Organization ID (RPO)” (field#35) – 30 C ***In Table B* “Source of Admission (UB)”** Added values A-F ***In Table G*** “***Servicing Provider type”*** removed option “-4 -Incomplete/No information”. **VI. *In 8.0 Quantity and Quality Edits, Reasonability and Validity Checks*** 1.Replaced “Filler” with “Header / Detail Claim Line Indicator” (field#7) 2, Updated definitions of MassHealth Standards in: “Admission Date’’ (field#15) ‘\Discharge Date’’(field#16) ‘’From Service Date’’(field#17) ‘’To Service Date” (field#18) ‘’Primary Diagnosis” (field#19) ‘’Type of Admission” (field24) “Source of Admission” (field25) “Procedure Code” (field26) “Revenue Code” (field 31) “Place of Service” (field 32) “Place of Service Type” (field 33) “Patient Discharge Status” (field 34) “Quantity” (field#36) “Servicing Provider ID” (field#50) “Billing Provider ID” (field#58) “DRG” (field#72) “New Member ID” (field#76) “Prescribing Prov. ID” (field#81) “Date Script Written” (field#82) “Admitting Diagnosis” (field#85) “Frequency” (field#91) “ICD Version Qualifier” (field#193)	
04/15/2015	**1. Updated a name of Monthly Financial Report in the examples with the current dates on pgs. 62-63.**	**Alla Kamenetsky**

Date	Description	Author
10/30/2014	**1. Added reference to One Care-ICO** **2. Changed Instructions on Monthly Financial Report. pg62-63** **3.Changed format of Provider_IDs paragraph on pg.10** **4. Changed length value in field #86 to 9. pg.47** **5. Changed length value in field #12 to 10. pg.55.** **6. Changed format of zip file name. pgs. 59-60** **7. Added Table I-C "Service Category (Using the One Care - ICO reporting groups)" pg.92**	**Alla Kamenetsky**
4/23/2014	**1. Added clarification in section 2.0 (Diagnosis Codes).** **2. Added clarification in section 8.0 on validation of ICD Version Qualifier (Field # 193), ICD Diagnosis and ICD Procedure codes**	**Rima Kayyali**
12/31/2013	**Deleted ICO Reference**	**Rima Kayyali**
12/17/2013	**Added value "5" for CarePlus population to field Group Number (field # 71)**	**Rima Kayyali**
11/26/2013	**Updated Appendix C (Section 9.3) for Member Enrollment File Specifications**	**Rima Kayyali**
8/13/2013	**Added Appendix C in Section 9.3 for Member Enrollment File Specifications**	**Rima Kayyali**

Date	Description	Author
4/26/2013	**1. Changed Encounter Data files submission requirement from fixed-length files to Pipe-delimited text files (delimiter=|) - Section 6.0** **2. Modified Table I – B (SCO Service Category) – Section 7.0** **3. Added an appendix for Provider Data File Guidelines – Section 9.0** **4. Modified "Inpatient Claim" Clarification – Section 2.0** **5. Added "Administrative Fees" Clarification – Section 2.0** **6. Added a value of '0' to "Primary Care Eligibility Indicator" field # 33 in Provider Data set – Section 3.1** **7. Added a clarifying note to "Rate Increase Indicator" Field # 200 – Section 3.0** **8. Clarified that the monthly financial report should include both MH and Comm Care Populations (Section 1.1), and that it should be submitted subsequent to submission of Manual Override (Section 6.0)**	**Rima Kayyali**
2/21/2013	**Modified Provider Data Record Layout, MCE Internal Provider Type and Metadata**	**Rima Kayyali**
1/17/2013	**Modified based on feedback received from MCE in 1/17/2013 meeting**	**Rima Kayyali**

Date	Description	Author
1/15/2013	Added Flags for "ACA 1202 Rate Increase" eligibility	Rima Kayyali
11/05/2012	Final Updates	Rima Kayyali
8/16/2012	Updates Based on Meeting Discussions	Rima Kayyali
6/6/2012	Updated Encounter Data Set Elements with additional fields. Updated Tables.	Rima Kayyali
11/22/2010	Added more detailed descriptions	Kelly Zeeh

Table of Contents

1.0 Introduction

MassHealth is required to build and maintain a database of health care services provided to Massachusetts Medicaid recipients enrolled in **managed care programs**. MassHealth will be using the database for a number of different projects; including Centers for Medicare and Medicaid Services (CMS) formerly HCFA reporting, program evaluation, and rate development. It is critical that each Managed Care Entity (MCO, MBHP, SCO, Care One (ICO) – all referred to as MCE in this document) provide MassHealth with records accurately reflecting all encounters provided to Medicaid recipients enrolled in its managed care program. Only with complete and accurate encounter data will MassHealth be able to assess the effectiveness of the managed care program.

This Encounter Data Set Request contains information on the data elements, format, and media requirements for submitting data to MassHealth for this project. Because data submission schedules are subject to frequent revision, they are not included in this document. A separate schedule has been provided to each MCE outlining the expected dates for data submission as well as defining the data ranges of data to be included in each submission.

MassHealth will expect the MCEs to provide new, replaced or voided claims in each feed. MassHealth will reject and return repeated claims to the MCEs with the appropriate error codes. MCEs will be expected to remove the offending claims from their next submission which will take place within a week. The submission-rejection-resubmission cycle will repeat iteratively until the number of rejected claims falls below a MassHealth defined threshold. If you cannot submit data in this fashion, or if you have any questions about any of these documents, please contact Prasad Balab 617-847-3360 (Email:***prasad.balab@state.ma.us)***

1.1 Data Requirements

- The data referred to in this document are encounter data, or records of health care services performed for Massachusetts Medicaid managed care beneficiaries. An encounter is defined as a unique service or procedure performed for the recipient. Multiple encounters can occur during a single visit to a provider, and each encounter should have a separate encounter record.

- Send all fully adjudicated paid claims. In the initialization feed, all claims should reflect the final status of the claim on the date it is pulled. All claims in the initialization feed should be marked as an Original claim. "**Paid**" claim is defined as any claim with at least one paid claim line.

- Submit one encounter record for each service performed (i.e., if a claim consisted of five services, each service should have a separate encounter record).

- Data should conform to the Record Layout specified later in this document. Any deviations from this format must be approved by MassHealth.

- Each row in a feed file shall have a unique Claim Number + Suffix combination. When the claim is not a "Void or Back out", MCEs shall submit **paid claim lines** only. Please contact MassHealth if MCE has any issues with submitting paid claim lines only.

- Submit only new or changed claims per feed. A feed shall consist of new [original] claims, replacements and voids. The replacements and voids shall have a former claim number and former suffix to associate them with the claim+suffix they are voiding or replacing.

- On receipt of a feed file MassHealth will scan the file for errors and return a file in the same format as the input with two extra columns to indicate errors. Corrections to the data shall be made and resubmitted within a week after MassHealth returns the error file. This cycle shall repeat until the number of errors in the input file falls below a MassHealth defined threshold for each MCE.

- Submit monthly financial reports to be validated against the Encounter Data in MassHealth data Warehouse. The monthly reports should follow the same logic as the quarterly financial reports (e.g., 4B reports for MCOs, financial reports for SCOs and Care One ICOs). Cost reported must be associated with dates of service during the reported month for claims paid through the end of the following month. For example, financial report for the month of March will be submitted in May for claims with dates of service from March 1 through March 31and paid through April 30. **For MCEs providing services to MassHealth and Commonwealth Care members, both populations should be included in the financial report.**

  This is a stand-alone summary report and should be submitted as a pipe-delimited text file. Please see "Monthly Financial Report" under section 6.0 - Media Requirements for specific instructions on report layout and submission.

1.2 How to Use this Document

This *Encounter Data Set Request* is intended as a reference document. Its purpose is to identify the types of data that MassHealth needs to build an encounter database. The goal of this document is to clarify the standard record layout, format, and values that MassHealth will accept.

Data Element Clarifications
MassHealth identified certain data elements that warranted further evaluation and clarification. These elements include: DRG, Diagnosis Codes, Procedure Codes, and Provider IDs. The information in the "Data Element Clarifications" section details what is currently expected for these data elements.

Data Elements
The information contained in the Data Elements section defines each of the fields included in the record layout. When appropriate, a list of valid values is included here. Nationally recognized coding schemes have been used whenever they exist.

Encounter Record Layout
This section details the record layout MCEs must use when creating the Encounter Data file. The same record layout is to be used for each Claim Category (facility, professional, dental, etc.). MassHealth requests that you provide a pipe-delimited text file, which means that each service line should be its own separate record. Follow instructions and clarifications specified in this document carefully before creating Encounter Data file. Contact MassHealth if you need further clarification.

Media Requirements and Data Formats
This section contains information on the types of data formats that MassHealth can accept. MCEs submit their data to MassHealth through a secure FTP server. Each MCE has a home directory on this server and will be given an ID with public key/private key based login. Please also note the security requirements for Internet transmissions noted in the Media Requirements section.

Standard Data Values
This section contains the tables referenced in the specific fields of the Data Elements section (Tables A through H).

Data Quality Checks
This section provides the validity and quality criteria that encounter data are expected to meet.

2.0 Data Element Clarifications

MassHealth has identified several data elements that require further clarification with respect to the expectations for those elements. The information in this section details MassHealth's expectations for Recipient Identifiers, Provider IDs, DRG, Diagnosis Codes (primary through fifth), and Procedure Codes.

Member Ids
Encounter data records must include MassHealth member IDs that are "active" as of the time of data submission.

Provider Ids
MassHealth is asking plans to provide an identifier that is unique to the plan. The acceptable ID types are:

ID Type	ID Description	Comments
1	NPI	Accepted for any provider including Referring and Prescribing Provider IDs. Note: MassHealth expects MCEs to submit MCE Internal ID in provider IDs and use NPI as a provider ID only when necessary and when an internal ID is not available. When NPI is used in Provider ID fields, provider file must have that same ID in Field #2 (Provider ID) and in field #26 (NPI). Field #26 (NPI) must also be populated for all other provider ID types except when it's not available like in the case of atypical providers.
6	MCE Internal ID	Accepted for any provider
8	DEA Number	Should be used with pharmacy claims only
9	NABP Number	Should be used with pharmacy claims only

As many of the provider attributes, NPI, Tax ID etc., should be filled out in the provider file as possible.

NPI
The Centers for Medicare & Medicaid Services (CMS) require all Medicare and Medicaid providers and suppliers of medical services that qualify for a National Provider Identifier (NPI) to include NPI on all claims. Type 1 NPI is for Health care providers who are individuals, including physicians, psychiatrists and all sole proprietors. Type 2 NPI is for Health care providers that are organizations, including physician groups, hospitals, nursing homes, and the corporations formed when an individual incorporates him/herself.

MCEs shall submit the individual NPI (Type1) for Servicing/Rendering, Referring, Prescribing and Primary Care Providers. MCEs shall submit individual (Type 1) or group (Type 2) NPI for billing providers and IPA/PMG. MassHealth will reject claims that point to a servicing/rendering, billing and referring provider with missing NPI in the Provider File with the exception of "atypical" providers.

DRG
The DRG field (field #72) is a field requested by CMS. Not all plans collect DRGs so MassHealth has developed a preferred course of action:

1. If a plan does collect DRGs, that plan should provide it on its data submissions.
2. If a plan does not collect DRGs, that plan should ensure that their primary, secondary, and tertiary diagnosis information is as complete and accurate as possible so that MassHealth may use a DRG grouper if necessary. Accurate procedure codes are also required for DRG assignment.
3. In the future, MassHealth may request that all plans provide DRGs.
4. MassHealth requests MCEs reporting DRGs to also report DRG related fields such as DRG Type, DRG Version, Severity of Illness level, and Risk of Mortality.

Diagnosis Codes

Requirements for validity and completeness are detailed in the ICD clinical guide that is published by the American Medical Association. MassHealth's current validating process requires that diagnosis codes contain the required number of digits outlined in the ICD code books.

Include in each Encounter Data submission the following diagnosis fields: Primary Diagnosis (field #19), Secondary Diagnosis (field #20), Tertiary Diagnosis (field #21), and all other Diagnosis listed in Data Elements. At least one diagnosis code is required for all provider types as specified in section 8.0.

Procedure Code
Many plans accept and use non-standard codes such as State specific and MCE specific codes. MassHealth's current validity process looks for standard codes only: CPT, HCPCS, and ADA.

HIPPAA regulations require that only standard HCPCS Level I (CPT) and II be used for reporting and data exchange.

The only field containing procedure codes is the Procedure Code field (field #26).

Capitation Payments
Capitation payment arrangement refers to a periodic payment per member, paid in advance to health care providers for the delivery of covered services to each enrolled member assigned to them. The same amount is paid for each period regardless of whether the member receives services or not during that period.

Note: Capitation payment is not "Bundled" payment usually paid for Episodes of care or other bundled services.

Dollar Amounts

MassHealth wants to ensure that the dollar amounts on the individual lines on the claim actually represent the actual or computed amount associated with each detail line. Therefore, whenever dollar amounts are not available at the detail level and the summary-level line is not available, the MCE shall add an extra detail line with a Record Indicator of 0 and report all summary-level amounts/quantities on that line, If the summary-level line is already available in the MCE source system and not artificially created, then it shall have a Record Indicator 6 (Bundled Summary-Level line) **unless** other Record Indicator values apply (like, for example, 5 for DRG).

All detail lines with 0 dollar amounts (are **not** artificially created and are **not** summary-level lines) shall have any Record Indicator value **other than** 0 or 6 as deemed appropriate by the MCE based on the definition of the Record Indicator values in the Record Indicator Table below.

For claims covered by capitation payments, MCE must report the equivalence of a capitation payment (either FFS equivalent amounts or amounts reported by the provider/vendor) on the claims, and use Record Indicator values 2 or 3 to indicate the type of payment arrangement.

Record Indicator Table:

Record Indicator	Dollar Amount Split
0: Artificial Line	Dollar amounts / quantities represent numbers that are available only at a summary level.
1: Fee-For-Service	Dollar amounts should be available at the detail line level in the source system.
2: Encounter Record with FFS equivalent	Dollar amounts should be available at the detail line level in the source system for a service provided under a capitation arrangement

Record Indicator Table (cont'd):

Record Indicator	Dollar Amount Split
3: Encounter Record w/out FFS equivalent	Dollar amount, if any, as reported by the provider or vendor to the MCE for a service provided under a capitation arrangement
4: Per Diem Payment	Total dollar amount for the entire stay. This is not the per-diem rate but the per-diem rate multiplied by the Quantity [numbers of days of inpatient admission. See Quantity]. If the amount applies to all lines on the claim, the claim must bring in a record with indicator = 0.
5: DRG Payment	Total dollar amount for the entire stay. If the amount applies to all lines on the claim, the claim must bring in a record with indicator = 0.
6: Bundled Summary-Level Line	Total dollar amount for a bundled summary-level claim line where the dollar amounts represent numbers that are available only at a summary line level in the source system and is not artificially

	created. A record with indicator = 6 for a **summary-level line of a bundled claim is used when none of the above payment arrangements apply**
7: Bundled detail line with 0 dollar amount	A bundled detail claim line where the dollar amounts are 0 or not available at the detail level. A record with indicator = 7 is used for a **detail-level line of a bundled claim when none of the above payment arrangements apply**

Below are few examples of possible scenarios for Record Indictor values:

Example 1 - Artificial Line 0 and Detail Lines with Record Indicator 4:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
44444444444	1	4 - Per Diem Payment	0
44444444444	2	4 - Per Diem Payment	0
44444444444	3	4 - Per Diem Payment	0
44444444444	4	4 - Per Diem Payment	0
44444444444	5	0 - Artificial Line: dollar amounts available at summary level only	260

Example 2 - Artificial Line 0 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
55555555555	1	7 - Bundled detail line with 0 dollar amount	0
55555555555	2	7 - Bundled detail line with 0 dollar amount	0
55555555555	3	0 - Artificial Line: dollar amounts available at summary level only	100

Example 3 – Bundled Summary Line 6 and Detail Lines with Record Indicator 7:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
66666666666	1	7 - Bundled detail line with 0 dollar amount	0
66666666666	2	7 - Bundled detail line with 0 dollar amount	0
66666666666	3	6 - Bundled Summary-Level Line	500

Example 4 – Bundled Summary Line 6 and Detail Lines with Record Indicator 1:

Claim Number	Claim Suffix	Record Indicator	Payment Amount
22222222222	1	1 - Fee-For-Service	0
22222222222	2	1 - Fee-For-Service	0
22222222222	3	6 - Bundled Summary-Level Line	500

Claim Number & Suffix

Every Original / Void or Replacement claim submitted to MassHealth shall have a new claim number + suffix combination. There can be no duplicate claim number + claim suffix in one feed

Former Claim Number & Suffix

In order to void or replace old transactions, MassHealth is requiring the MCEs including MBHP to add the former claim number and suffix to the claim lines of record type 'R', 'V'. MassHealth's objective is to get a snapshot of the claims at the end of each period after all debit or credit transactions have been applied to them.

Examples:

Adjustments:

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Payment Amount
XXX	11111111111	4	1	O			10
XXX	33333333333	4	1	R	11111111111	4	20
XXX	88888888888	4	1	R	33333333333	4	25

Voids:

Claim Payer	Claim Number	Claim Suffix	Claim Category	Record Type	Former Claim Number	Former Claim Suffix	Payment Amount
XXX	66666666666	1	1	O			15
XXX	77777777777	2	1	V	66666666666	1	10
XXX	99999999999	1	1	O			30

Record Creation Date

This is the date on which the claim was created in the MCE's database. If a replacement record represents the final result of multiple adjustments to a claim between submissions this date shall be the date of the last adjustment to that claim. For encounter records [Record Indicator 2 or 3] this shall be the same as the Paid Date.

Inpatient Claim

MassHealth defines Inpatient Claim in Encounter Data based on the following logic:

Claim Category = 1 (Facility) and either one of the following:

- Place Of Service Type = 1 (CMS 1500 – Table C) AND Place of Service = 21 (Inpatient Hospital) Or

- Place of Service Type = 2 (UB Bill) AND First position of the Place of Service field (UB Bill) does NOT equal 3, 7, or 8 (excludes Home Health, Clinics, or Special Facility) AND second position of Place of Service field (UB Bill) is 1 (Inpatient including Medicare Part A) Or

- Place of Service Type = 2 (UB Bill) AND First position of the Place of Service field (UB Bill) does NOT equal 3, 7 (excludes Home Health, or Clinics) AND second position of Place of Service field (UB Bill) is 2 (Inpatient Medicare Part B), or 6 (Complementary Inpatient).

Administrative Fees

Administrative Fees such as PBM fees should not be reported in the encounter data as part of the "Net Payment Amount". MCEs should inform EOHHS of any arrangement where these fees are included in their claims processing, and should work with their PBM or other agencies to separate out the administrative fees from the encounter cost component in their claim processing**.**

Bundle Indicator, Claim Number & Suffix

The Bundle indicator is a Y/N field to indicate that the claim line is part of a bundle. This indicator should always be 'Y' for **all** bundled claims (see example 1 and 2). The Bundle Claim Number and Suffix refer to the claim number and the claim suffix of the claim line with the bundled payment. The examples below illustrate how these two fields should be populated. Example 1 illustrates a scenario with one bundle within a claim, Example 2 illustrates a scenario with multiple bundles within a claim, and Example 3 illustrates a scenario with one bundle across multiple claims.

The assumption is that when a bundled claim line gets adjusted, all bundled claim lines for that claim would be adjusted as well. Please see Examples 4 and 5 below for scenarios where there is an adjustment of a bundled claim. MCE should leave the Bundle claim number and suffix blank when this assumption is inaccurate and when they do not have this information. However, these two fields are expected when MCE have this information in their system. Bundle Indicator should be provided on all bundled claims with no exception.

Example 1 – One Bundle per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	AAAAAAAA	1	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	2	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	3	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	4	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	5	Y	AAAAAAAA	6	0
XXX	AAAAAAAA	6	Y	AAAAAAAA	6	120

Example 2 – Two Bundles per Claim Number:

Claim Payer	Claim Number	Claim Suffix	Bundle Ind	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	CCCCCCCC	1	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	2	Y	CCCCCCCC	3	0
XXX	CCCCCCCC	3	Y	CCCCCCCC	3	60
XXX	CCCCCCCC	4	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	5	Y	CCCCCCCC	6	0
XXX	CCCCCCCC	6	Y	CCCCCCCC	6	80

Example 3 One Bundle for Two Claim Numbers:

Claim Payer	Claim Number	Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount
XXX	DDDDDDDD	1	NNNNNNNN	1	0
XXX	DDDDDDDD	2	NNNNNNNN	1	0
XXX	DDDDDDDD	3	NNNNNNNN	1	0
XXX	NNNNNNNN	1	NNNNNNNN	1	50

Example 4 – Adjustment/Void of Bundled Claims with Record Indicator 0:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount	Record Indicator	Procedure Code
XXX	44444444444	1	O			44444444444	4	0	4	96360
XXX	44444444444	2	O			44444444444	4	0	4	96375
XXX	44444444444	3	O			44444444444	4	0	4	96376
XXX	44444444444	4	O			44444444444	4	260	0	96366
XXX	55555555555	1	R	44444444444	1	55555555555	4	0	4	96360
XXX	55555555555	2	V	44444444444	2	55555555555	4	0	4	96375
XXX	55555555555	3	R	44444444444	3	55555555555	4	0	4	96376
XXX	55555555555	4	R	44444444444	4	55555555555	4	200	0	96366

Example 5 – Adjustment/Void of Bundled Claims with Record Indicator 6:

Claim Payer	Claim Number	Claim Suffix	Record Type	Former Claim Number	Former Claim Suffix	Bundle Claim Number	Bundle Claim Suffix	Payment Amount	Record Indicator	Procedure Code
XXX	66666666666	1	O			66666666666	3	0	7	96375
XXX	66666666666	2	O			66666666666	3	0	7	96376
XXX	66666666666	3	O			66666666666	3	500	6	96366
XXX	77777777777	1	R	66666666666	1	77777777777	3	0	7	96375
XXX	77777777777	2	V	66666666666	2	77777777777	3	0	7	96376
XXX	77777777777	3	R	66666666666	3	77777777777	3	400	6	96366

3.0 Encounter Data Set Elements

Data Elements

This section contains field names and definitions for the encounter record. It is divided into five sections:

- Demographic Data
- Service Data
- Provider Data
- Financial Data
- Medicaid Program-Specific Data

For fields which contain codified values (e.g. Patient Status), we have used values which are national standards (e.g. UB92 coding standards) whenever possible.

The value 'X' indicates that the data element is applicable under each Claim Category. The columns are labeled as:

- H – Facility (*except Long Term Care*)
- P – Professional
- L – Long Term Care
- R – Prescription Drug
- D – Dental

Programs with withhold amount

If the managed care program includes withhold risk-sharing arrangement with the providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also be included in the eligible charge and net payment fields.

Demographic Data

#	Field Name	Definition/Description	H	P	L	R	D
1	Claim Payer	**This code identifies your Managed Care Organization (MCO):** 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England xxxx MassHealth PCC Plan **This code identifies your Senior Care Organization (SCO):** 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan **This code identifies your One Care Organization (ICO)**: 601 Commonwealth Care Alliance 602 Network Health 603 Fallon Total Care	X	X	X	X	X
2	Claim Category	A code indicating the category of this claim. Valid values are: 1 = Facility (*except Long Term Care*) 2 = Professional (includes transportation claims) 3 = Dental 4 = Vision 5 = Prescription Drug 6 = Long Term Care *(Nursing Home, Chronic Care & Rehab)*	X	X	X	X	X
3	Plan Identifier	Current New MMIS code indicating the MCE or specific health plan within an MCE which is submitting the data. (Current Medicaid Provider ID of the MCE). Do not submit legacy IDs	X	X	X	X	X
4	Record Indicator	This information refers to the payment arrangement under which the rendering provider was paid. Value identifies whether the record was a fee-for-service claim, or a service provided under a capitation arrangement (encounter records). For encounter records, indicate whether or not there are Fee-For-Service (FFS) equivalents and payment amounts on the record. 0 Artificial record – Refers to a line item inserted to hold amounts / quantities available only at a summary (claim) level. 1 Claim Record – Refers to a claim paid on a Fee-For-Service (FFS) basis	X	X	X	X	X

Demographic Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
	Record Indicator (Continued)	2 Encounter Record with FFS equivalent - Refers to services provided under a capitation arrangement and for which a FFS equivalent is given 3 Encounter Record w/out FFS equivalent - Refers to services provided under a capitation arrangement but for which no FFS equivalent is available 4 Per Diem Payment - Refers to a record for an inpatient stay paid on a per diem basis. 5 DRG Payment - Refers to a record for an inpatient stay paid on a DRG basis 6 Bundled Summary-Level Line – Refers to a record with a bundled summary-level amounts/quantities as available in the MCE source system. Use this value when none of the above values apply. 7 Bundled detail line with 0 dollar amount – Refers to a bundled detail claim line where the dollar amounts are 0 or not available at the detail level. Use this value when none of the above values apply ***See discussion under Dollar Amounts in the Data Elements Clarification Section.***					
5	Claim Number	A unique number assigned by the administrator to this claim (e.g., ICN, TCN, DCN). It is very important to include a Claim Number on each record since this will be the key to summarizing from the service detail to the claim level. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X
6	Claim Suffix	This field identifies the line or sequence number in a claim with multiple service lines. ***See discussion under Claim Number/Suffix in the Data Elements Clarification Section***	X	X	X	X	X
7	FILLER		X	X	X	X	X
8	Recipient DOB	The birth date of the patient expressed as YYYYMMDD. For example, August 31, 1954 would be coded "19540831".	X	X	X	X	X
9	Recipient Gender	The gender of the patient: 1 = Male 2 = Female	X	X	X	X	X
10	Recipient ZIP Code	The ZIP Code of the patient's residence as of the date of service.	X	X	X	X	X
11	Medicare Code	A code indicating if Medicare coverage applies and, if so, the type of Medicare coverage. 0= No Medicare 1 = Part A Only 2 = Part B Only 3 = Part A and B	X	X	X	X	X

Service Data

#	Field Name	Definition/Description	H	P	L	R	D

12	Other Insurance Code	A Yes/No flag that indicates whether or not third party liability exists. 1 = Yes; 2 = No	X	X	X	X	X
13	FILLER		X	X	X	X	X
14	Claim Type	MBHP Specific field	X	X	X	X	X
15	Admission Date	For facility services, the date the recipient was admitted to the facility. The format is YYYYMMDD.	X		X		
16	Discharge Date	For facility services, the date the recipient was discharged from the facility. The format is YYYYMMDD. Cannot be prior to Admission Date.	X		X		
17	From Service Date	The actual date the service was rendered; if services were rendered over a period of time, this is the date of the first service for this record. The format is YYYYMMDD.	X	X	X	X	X
18	To Service Date	The last date on which a service was rendered for this record. The format is YYYYMMDD.	X	X	X		X
19	Primary Diagnosis	The ICD diagnosis code chiefly responsible for the hospital confinement or service provided. The code should be left justified, coded to the fifth digit when applicable (blank filled when less than five digits are applicable). *DO NOT include decimal points in the code.* ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X
20	Secondary Diagnosis	The ICD diagnosis code explaining a secondary or complicating condition for the service. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
21	Tertiary Diagnosis	The tertiary ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
22	Diagnosis 4	The fourth ICD diagnosis code. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
23	Diagnosis 5	The fifth ICD diagnosis code. See above for format. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
24	Type of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table A.	X		X		
25	Source of Admission	Should be valid and present on all Hospital and Long Term Care claims with hospital admission. For the UB standard values see Table B	X		X		

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
26	Procedure Code	A code explaining the procedure performed. This code may be any valid code included in the coding systems identified in the Procedure Type field below. *Any internal coding systems used must be translated to one of the coding systems identified in field #**30** below.* Should not contain ICD procedure codes. All ICD procedure codes should be submitted in the surgical procedure code fields (#101 – #113) ***including the ICD-treatment procedure codes*** ***See discussion in Data Element Clarifications section.***	X	X	X		X
27	Procedure Modifier 1	A current procedure code modifier (CPT or HCPCS) corresponding to the procedure coding system used, when applicable.	X	X	X		X
28	Procedure Modifier 2	Second procedure code modifier, required, if used.	X	X	X		X
29	Procedure Modifier 3	Third procedure code modifier, required, if used.	X	X	X		X
30	Procedure Code Indicator	A code identifying the type of procedure code used in field#26: 2= CPT or HCPCS Level 1 Code 3= HCPCS Level II Code 4= HCPCS Level III Code (State Medicare code). 5= American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 6= State defined Procedure Code 7= Plan specific Procedure Code ICD procedure codes should go in surgical procedure code fields (Field # 103 – 111) *State defined procedure codes should be used, when coded, for services such as EPSDT procedures.* ***See discussion in the Data Element Clarifications section.***	X	X	X		X
31	Revenue Code	For facility services, the UB Revenue Code associated with the service. *Only standard UB92 Revenue Codes values are allowed; plans may **not** use "in house" codes. Revenue code less than 4 digits long should be submitted with one leading zero. For Example:* *a. Revenue code 1 should be submitted as '01';* *b. Revenue Code 23 - as '023;* *c. Revenue code 100 - as '0100';* *d. Revenue Code 2100 – as '2100'.*	X		X		
32	Place of Service	This field hosts both, the Place of Service (POS) that comes on the Professional claim and the Type of Bill (TOB) that comes on the Institutional claims. It is essential to submit correct information that corresponds to Place of Service Type (field #33). See Table C for CMS 1500 standard or Table D for the UB Type of Bill values indicating place. ***Note*: for** UB Type of Bill, use the 1st and 2nd positions only.)	X	X	X		X

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
33	Place of Service Type	The value in this field indicates whether the Place of Service field (#32) contains Place of Service (POS) or Type of Bill (TOB). Can be submitted as '1' or '2'. The type of code provided: 1 = Place of Service on CMS 1500/Professional claims 2 = Type of Bill on UB04/Institutional claims. The codes need to be consistent. For example, Place Of Service Type= 1 (for Professional claim) will ***not*** be allowed on a claim with Claim Category =1 for Facility or Institutional claim.	X	X	X		X
34	Patient Discharge Status	This is 2-digit Discharge Status Code (UB Patient Status) for hospital admissions. Values from 1 to 9 should always be entered with leading '0'. Examples: a. Patient Discharge Status '1' should be submitted as '01'; b. Patient Discharge Status '19' should be submitted as '19'.	X		X		
35	Type of Service	A code indicating the type of service to which this encounter or claim belongs. (Use CMS 1500 standard, see Table F)		X			
36	Quantity	This value represents the actual quantity and should be submitted with decimal point when applicable. For inpatient admissions, the number of days of confinement. Count the day of admission but not the day of discharge (for admission and discharge on the same day, Quantity is counted as 1). For all other procedures, the number of units performed for this procedure. For most procedures, this number should be "1". In some cases, a procedure may be repeated, in which case this number should reflect the number of times the procedure was performed. For anesthesia services, this should be the total number of minutes that make up the beginning and ending clock time of anesthesia service administered. Please make sure that the Quantity corresponds to the procedure code. For example, if the psychiatric code 90844 is used (Individual psychotherapy, 45-50 minutes), the Quantity should be "1" NOT "45" or "50". For Inpatient records, it should represent number of days of care. Values of 30, 60 or 100 are most common on drug records. Note: Length of this field has been increased to accommodate the actual quantity. Quantity=10 should be submitted as 10; Quantity=10.5 should be submitted as 10.5; Quantity=10.55 should be	X	X	X		X

		submitted as 10.55					

Service Data (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
37	NDC Number	For prescription drugs, the valid National Drug Code number assigned by the Food and Drug Administration (FDA). For Compound drugs claims submit NDC Number for the primary drug, If primary drug is unknown, submit NDC Number for most expensive drug. NDC codes having less than 11 digits should be submitted with leading 0's. For Example NDC "603373932" should be submitted as "00603373932".	X	X		X	
38	Metric Quantity	For prescription drugs, the total number of units or volume (e.g., tablets, milligrams) dispensed. Should be submitted with decimal point when applicable. Note: Length of this field has been increased to accommodate the actual Metric Quantity. Metric Quantity=10 should be submitted as 10; Metric Quantity=10.5 should be submitted as 10.5; Metric Quantity=10.55 should be submitted as 10.55	X	X		X	
39	Days Supply	The number of days of drug therapy covered by this prescription.				X	
40	Refill Indicator	A number indicating whether this is an original prescription (0) or a refill number (e.g., 1, 2, 3, etc.) on Pharmacy claims.				X	
41	Dispense As Written Indicator	An indicator specifying why the product dispensed was selected by the pharmacist and should be entered in a 2 digit format with leading zero: 00 = No DAW 01 = Physician DAW 02 = Patient DAW 03 = Pharmacist DAW 04 = Generic Not In Stock 05 = Brand Dispensed as Generic 06 = Override 07 = Brand Mandated by Law 08 = No Generic Available 09 = Other				X	
42	Dental Quadrant	One of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth. 1 = Upper Right 2 = Upper Left 3 = Lower Left 4 = Lower Right					X
43	Tooth Number	The number or letter assigned to a tooth for identifications purposes as specified by the American Dental Association. A - T (for primary teeth) 1 - 32 (for secondary teeth)					X
44	Tooth Surface	The tooth surface on which the service was performed: M = Mesial D = Distal O = Occlusal L = Lingual					X

		I = Incisal F = Facial B = Buccal A = All 7 surfaces This field can list up to six values. When multiple surfaces are involved, please list the value for each surface without punctuation between values. For example, work on the mesial, occlusal, and lingual surfaces should be listed as “MOL “(three spaces following the third value).					
45	Paid Date	For encounter records, the date on which the record was processed. For services performed on a fee-for-service basis, the date on which the claim was paid. The format is YYYYMMDD.	X	X	X	X	X
46	Service Class	MBHP Specific field	X	X	X	X	X

Provider Data

#	Field Name	Definition/Description	H	P	L	R	D
47	PCP Provider ID	A unique identifier for the Primary Care Physician selected by the patient as of the date of service. ***See discussion in the Data Element Clarifications section.***	X	X	X		X
48	PCP Provider ID Type	A code identifying the type of ID provided in PCP Provider ID above. For example, 6 = Internal ID (Plan Specific)	X	X	X		X
49	IPA/PMG ID	The plan specific reference that identifies the Primary Medical Group (PMG) or Independent Physician Association (IPA) with which the primary care provider is associated. If the PCP is a solo practitioner, please provide the internal plan ID.	X	X	X		X
50	Servicing Provider ID	A unique identifier for the provider performing the service. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X
51	Servicing Provider ID Type	A code identifying the type of ID provided in Servicing Provider ID above. For example, 6 = Internal ID (Plan Specific) 9 = NAPB Number (for pharmacy claims only)	X	X	X	X	X
52	Referring Provider ID	A unique identifier for the provider. ***See discussion in the Data Element Clarifications section.***	X	X	X	X	X
53	Referring Provider ID Type	A code identifying the type of ID provided in Referring Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number (for pharmacy claims only)	X	X	X	X	X
54	Servicing Provider Class	A code indicating the class for this provider: 1 = Primary Care Provider 2 = In plan provider, non PCP 3 = Out of plan provider Note: This code relates to the class of the provider and a PCP does not necessarily indicate the recipient's selected or assigned PCP. PCP class should be assigned only to those physicians whom the plan considers to be a participating PCP.	X	X	X	X	X
55	Servicing Provider Type	A code indicating the type of provider rendering the service represented by this encounter or claim. (Use Servicing Provider Type values, see Table G)	X	X	X	X	X
56	Servicing Provider Specialty	The specialty code of the servicing provider. (Use CMS 1500 standard, see Table H)	X	X	X		X
57	Servicing Provider ZIP Code	The servicing provider's ZIP code. The ZIP code where the service occurred is preferred.	X	X	X	X	X
58	Billing Provider ID	A unique identifier for the provider billing for the service.	X	X	X	X	X
59	Authorization Type	MBHP Specific field	X	X	X	X	X

Financial Data

Most of the fields below apply to services for which reimbursement is made on a fee-for-service basis. For capitated services, the record should include fee-for-service equivalent information when available. Line item amounts are required for these fields.

#	Field Name	Definition/Description	H	P	L	R	D
60	Billed Charge	The amount the provider billed for the service.	X	X	X	X	X
61	Gross Payment Amount	The amount that the provider was paid in total by all sources for this service. *NOTE: This field should include any withhold amount, if applicable.*	X	X	X	X	X
62	TPL Amount	Any amount of third party liability paid by another medical coverage carrier for this service. If the TPL amount is available only at the summary level, it must be recorded on a special line on the claim which will have a record indicator value of 0. See Dollar Amounts.	X	X	X	X	X
63	Medicare Amount	Any amount paid by Medicare for this service.	X	X	X	X	X
64	Copay/ Coinsurance	Any co-payment amount the member paid for this service.	X	X	X	X	X
65	Deductible	Any deductible amount the member paid for this service.	X	X	X	X	X
66	Ingredient Cost	The cost of the ingredients included in the prescription.				X	
67	Dispensing Fee	The dispensing fee charged for filling the prescription.				X	
68	Net Payment	The amount the Medicaid MCE paid for this service. (Should equal Eligible Charges less COB, Medicare, Copay/Coinsurance, and Deductible.)	X	X	X	X	X
69	Withhold Amount	Any amount withheld from fee-for-service payments to the provider to cover performance guarantees or as incentives.	X	X	X		X
70	Record Type	A code indicating the type of record: O = Original V = Void or Back Out R = Replacement A = Amendment ***See discussion under 'Former Claim Number / Suffix' in the Data Elements Clarification Section***	X	X	X	X	X
71	Group Number	For non-MHSA MCEs 1 = MCO MassHealth 2 = MCO Commonwealth Care 3 = SCO 5 = CarePlus 6 = One Care (ICO)	X	X	X	X	X

Medicaid Program-Specific Data

#	Field Name	Definition/Description	H	P	L	R	D
72	DRG	The DRG code used to pay for an inpatient confinement and should always be submitted in 3-digit format. One and two digit codes should be completed with leading zeros to comply. For example: a. DRG code '1' should be submitted as '001'; b. DRG code '25' should be submitted as '025'; c. DRG code '301' should be submitted as '301'. ***See discussion in the Data Element Clarifications section***.	X		X		
73	EPSDT Indicator	A flag that indicates those services which are related to EPSDT: 1 = EPSDT Screen 2 = EPSDT Treatment 3 = EPSDT Referral		X			X
74	Family Planning Indicator	A flag that indicates whether or not this service involved family planning services, which may be matched by CMS at a higher rate: 1 = Family planning services provided 2 = Abortion services provided 3 = Sterilization services provided 4 = No family planning services provided (see Table I)	X	X		X	
75	MSS/IS	*Please leave this field blank, it will be further defined at a later date.* A flag that indicates services related to MSS/IS: 1 = Maternal Support Services 2 = Infant Support Services		X			
76	New Member ID	The ***"Active" Medicaid*** identification number assigned to the individual. This number is assigned by MassHealth and may change.	X	X	X	X	X

Other Fields

#	Field Name	Definition/Description	H	P	L	R	D
77	Former Claim Number	If this is not an Original claim [Record Type = 'O'], then the previous claim number that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X
78	Former Claim Suffix	If this is not an Original claim [Record Type = 'O'], then the previous claim suffix that this claim is replacing/voiding. ***See discussion under Former Claim Number / Suffix in the Data Elements Clarification Section***	X	X	X	X	X
79	Record Creation Date	The date on which the record was created. ***See discussion under Record Creation Date in the Data Elements Clarification Section.***	X	X	X	X	X
80	Service Category	Service groupings from financial reports like 4B (see Table I)	X	X	X	X	X
81	Prescribing Prov. ID	Federal Tax ID or UPIN or other State assigned provider ID for the prescribing provider on the Pharmacy claim.				X	
82	Date Script Written	Date prescribing provider issued the prescription.				X	
83	Compound Indicator	Indicates that the prescription was a compounded drug. 1 = Yes 2 = No				X	
84	Rebate Indicator	PBM received rebate for drug dispensed. 1 = Yes 2 = No				X	
85	Admitting Diagnosis	Diagnosis upon admission. May be different from principal diagnosis. Should not be External Injury codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
86	Allowable Amount	Amount allowed under the Health Plan formulary.	X	X	X	X	X
87	Attending Prov. ID	Provider ID of the provider who attended at facility. Federal Tax ID or UPIN or other State assigned provider ID.	X				
88	Non-covered Days	Days not covered by Health Plan.	X		X		
89	External Injury Diagnosis 1	If there is an External Injury Diagnosis code 1 (ICD E-Code) present on the claim, it should be submitted in this field. See above for format. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
90	Claim Received Date	Date claim received by Health Plan, if processed by a PBM.				X	
91	Frequency	The third digit of the UB92 Bill Classification field.	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
92	IPA/PMG ID_Type	A code identifying the type of ID provided in IPA/PMG ID Provider ID above: 6 = Internal ID (Plan Specific)	X	X	X		X
93	Billing Provider ID _Type	A code identifying the type of ID provided in Billing Provider ID above. For example, 6 = Internal ID (Plan Specific) *9 = NABP Number* (for pharmacy claims only)	X	X	X	X	X
94	Prescribing Prov. ID _Type	A code identifying the type of ID provided in Prescribing Provider ID above. For example, 1 = NPI 6 = Internal ID (Plan Specific) 8 = DEA Number				X	
95	Attending Prov. ID _Type	A code identifying the type of ID provided in Attending Prov. ID above. For example, *6 = Internal ID (Plan Specific)*	X				
96	Admission Time	For inpatient facility services, the time the recipient was admitted to the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X		
97	Discharge Time	For inpatient facility services, the time the recipient was discharged from the facility. If not an inpatient facility, the value should be missing. This field ***must*** be in HH24MI format. For example, 10:30AM would be 1030 and 10:30PM would be 2230.	X		X		
98	Diagnosis 6	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
99	Diagnosis 7	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
100	Diagnosis 8	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
101	Diagnosis 9	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
102	Diagnosis 10	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
103	Surgical Procedure code 1	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
104	Surgical Procedure code 2	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
105	Surgical Procedure code 3	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
106	Surgical Procedure code 4	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
107	Surgical Procedure code 5	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
108	Surgical Procedure code 6	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
109	Surgical Procedure code 7	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
110	Surgical Procedure code 8	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
111	Surgical Procedure code 9	For surgical revenue codes, the ICD surgical procedure code. If a surgical revenue code is not applicable, the value should be left blank. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X				
112	Employment	Is the patient's condition related to Employment Y N	X	X	X	X	X
113	Auto Accident	Is the patient's condition related to an Auto Accident Y N	X	X	X	X	X
114	Other Accident	Is the patient's condition related to Other Accident Y N	X	X	X	X	X
115	Total Charges	This field represents the total charges, covered and uncovered related to the current billing period.	X	X	X	X	X
116	Non Covered charges	This field represents the uncovered charges by the payer related to the revenue code. This is the amount, if any, that is not covered by the primary	X	X	X	X	X

#	Field Name	Definition/Description	H	P	L	R	D
		payer for this service.					
117	Coinsurance	Any coinsurance amount the member paid for this service.	X	X	X	X	X
118	Void Reason Code	The reason the claim line was voided 1 TPL 2 accident recovery 3 provider audit recoveries 4 Other	X	X	X	X	X
119	DRG Description	Description of DRG Code	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
120	DRG Type	*Values:* 1=Medicare CMS-DRG 2=Medicare MS-DRG 3=Refined DRGs (R-DRG) 4=All Patient DRGs (AP-DRG) 5=Severity DRGs (S-DRG) 6=All Patient, Severity-Adjusted DRGs (APS-DRG) 7=All Patient Refined DRGs (APR-DRG) 8=International-Refined DRGs (IR-DRG) 9=Other ***Please use the accurate and specific DRG type and avoid using the value "Other". Please communicate to MassHealth any DRG types you are using that are missing from the above list***	X		X		
121	DRG Version	DRG Version number associated with DRG type	X		X		
122	DRG Severity of Illness Level	A code that describes the Severity of the claim with the assigned DRG: Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields***	X		X		
123	DRG Risk of Mortality Level	A code that describes the Mortality of the patient with the assigned DRG code. Valid values are: 1 = minor 2 = moderate 3 = major 4 = extreme ***Associated with DRG Type=APR-DRG (DRT Type =7) or any other DRG that has these fields.***	X		X		
124	Patient Pay Amount	Patient paid amount for nursing facility stays and hospitals	X		X		
125	Patient Reason for Visit Diagnosis 1	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
126	Patient Reason for Visit Diagnosis 2	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
127	Patient Reason for Visit Diagnosis 3	ICD diagnosis code describing the patient's (or patient representative's) stated reason for seeking care at the time of outpatient (ER) visit ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
128	Present on Admission (POA) 1	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
129	Present on Admission (POA) 2	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
130	Present on Admission (POA) 3	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
131	Present on Admission (POA) 4	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
132	Present on Admission (POA) 5	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
133	Present on Admission (POA) 6	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
134	Present on Admission (POA) 7	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
135	Present on Admission (POA) 8	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
136	Present on Admission (POA) 9	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
137	Present on Admission (POA) 10	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
138	Diagnosis 11	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
139	Present on Admission (POA) 11	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
140	Diagnosis 12	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		
141	Present on Admission (POA) 12	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
142	Diagnosis 13	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
143	Present on Admission (POA) 13	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
144	Diagnosis 14	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
145	Present on Admission (POA) 14	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
146	Diagnosis 15	The ICD diagnosis code. ***See discussion in Data Element Clarifications***	X		X		

#	Field Name	Definition/Description	H	P	L	R	D
		section, including clarification on ICD-10					

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
147	Present on Admission (POA) 15	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
148	Diagnosis 16	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
149	Present on Admission (POA) 16	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
150	Diagnosis 17	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
151	Present on Admission (POA) 17	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
152	Diagnosis 18	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
153	Present on Admission (POA) 18	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
154	Diagnosis 19	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
155	Present on Admission (POA) 19	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
156	Diagnosis 20	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
157	Present on Admission (POA) 20	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
158	Diagnosis 21	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
159	Present on Admission (POA) 21	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
160	Diagnosis 22	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
161	Present on Admission (POA) 22	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
162	Diagnosis 23	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
163	Present on Admission (POA) 23	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
164	Diagnosis 24	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
165	Present on Admission (POA) 24	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
166	Diagnosis 25	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
167	Present on Admission (POA) 25	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
168	Diagnosis 26	The ICD diagnosis code. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
169	Present on Admission (POA) 26	This is an indicator that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
170	Present on Admission (POA) EI 1	This is an indicator associated with External Injury Diagnosis 1 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
171	External Injury Diagnosis 2	If there is an External Injury Diagnosis code 2 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
172	Present on Admission (POA) EI 2	This is an indicator associated with External Injury Diagnosis 2 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
173	External Injury Diagnosis 3	If there is an External Injury Diagnosis code 3 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
174	Present on Admission (POA) EI 3	This is an indicator associated with External Injury Diagnosis 3 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
175	External Injury Diagnosis 4	If there is an External Injury Diagnosis code 4 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
176	Present on Admission	This is an indicator associated with External Injury Diagnosis 4 that clarifies if the diagnosis was present	X		X		

	(POA) EI 4	at admission. This only applies to UB-04 claims (See Table M for values)					

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
177	External Injury Diagnosis 5	If there is an External Injury Diagnosis code 5 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
178	Present on Admission (POA) EI 5	This is an indicator associated with External Injury Diagnosis 5 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
179	External Injury Diagnosis 6	If there is an External Injury Diagnosis code 6 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
180	Present on Admission (POA) EI 6	This is an indicator associated with External Injury Diagnosis 6 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
181	External Injury Diagnosis 7	If there is an External Injury Diagnosis code 7 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
182	Present on Admission (POA) EI 7	This is an indicator associated with External Injury Diagnosis 7 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
183	External Injury Diagnosis 8	If there is an External Injury Diagnosis code 8 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
184	Present on Admission (POA) EI 8	This is an indicator associated with External Injury Diagnosis 8 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
185	External Injury Diagnosis 9	If there is an External Injury Diagnosis code 9 (ICD E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
186	Present on Admission (POA) EI 9	This is an indicator associated with External Injury Diagnosis 9 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
187	External Injury Diagnosis 10	If there is an External Injury Diagnosis code 10 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications***	X		X		

		section, including clarification on ICD-10					

Other Fields (cont'd)

#	Field Name	Definition/Description	H	P	L	R	D
188	Present on Admission (POA) EI 10	This is an indicator associated with External Injury Diagnosis 10 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
189	External Injury Diagnosis 11	If there is an External Injury Diagnosis code 11 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
190	Present on Admission (POA) EI 11	This is an indicator associated with External Injury Diagnosis 11 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
191	External Injury Diagnosis 12	If there is an External Injury Diagnosis code 12 (ICD-E-Code) present on the claim, it should be submitted in this field. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X		X		
192	Present on Admission (POA) EI 12	This is an indicator associated with External Injury Diagnosis 12 that clarifies if the diagnosis was present at admission. This only applies to UB-04 claims (See Table M for values)	X		X		
193	ICD Version Qualifier	ICD9 or ICD10. The value "ICD9" must be populated on claim records with either ICD-9-CM diagnosis codes or ICD-9-CM procedure codes. The value "ICD10" must be populated on claim records with either ICD-10-CM diagnosis codes or ICD-10-CM procedure codes. One claim record must ***never*** have a combination of ICD9 and ICD10 codes. ***See discussion in Data Element Clarifications section, including clarification on ICD-10***	X	X	X		X
194	Procedure Modifier 4	4th procedure code modifier, required, if used.	X	X	X		X
195	Service Category Type	This field describes the Type of Financial reports the service category is based on. The values are: '4B' for MCO Service Categories 'SCO' for SCO Service Categories 'ICO' for Care One (ICO) Service Categories	X	X	X	X	X
196	Ambulance Patient Count	AMBULANCE PATIENT COUNT. REQUIRED WHEN MORE THAN ONE PATIENT IS TRANSPORTED IN THE SAME VEHICLE FOR AMBULANCE OR NON-EMERGENCY TRANSPORTATION SERVICES.		X			
197	Obstetric Unit Anesthesia Count	The number of additional units reported by an anesthesia provider to reflect additional complexity of services.		X			
198	Prescription	Rx Number.				X	

#	Field Name	Definition/Description	H	P	L	R	D
	Number						
199	Taxonomy Code	This is the Taxonomy code for Servicing Provider identified on the claim. Taxonomy codes are National specialty codes used by providers to indicate their specialty. These codes can be found on the Website of Centers for Medicare & Medicaid Service (CMS)	X	X	X		X
200	Rate Increase Indicator	Indicates if the provider is eligible to receive the enhanced primary care rate ***for this service***, as specified in the Affordable Care Act – Section 1202 final regulations. 1=Yes 2=No 3=Unknown 4=Not Applicable **Note: If a service is considered eligible based on the ACA regulations, then the value should be equal to "1" even if the MCE is already paying the provider at the higher rate.**	X	X	X		
201	Bundle Indicator	Indicates if the claim line is part of a bundle. Values: Y=Yes, the claim line is part of a bundle. All bundled lines including the line with the bundled payment should have a value of 'Y' N=No, the claim line is not part of a bundle.	X	X	X	X	X
202	Bundle Claim Number	This is the claim number of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section,***	X	X	X	X	X
203	Bundle Claim Suffix	This the claim suffix of the claim line with the bundled payment. ***See discussion in Data Element Clarifications section,***	X	X	X	X	X

3.1 Provider Data Set

Data Elements
This section contains field names and definitions for the provider record. If ***necessary***, due to changes in provider contract status, you may provide multiple records per provider if provider effective and term dates are populated accurately. To be able to link providers across MCEs, it is essential to accurately report as many data elements as possible especially 2 through 11, 26, 30 and 33. Please read Appendix 'A' in section 9.0 for guidelines on Provider file.

File Processing
All fields should be submitted when available including:

1. Tax Id Number when available (filed#30);
2. APCD ORG ID when available in APCD data (filed#34);

Reject file if:

a. NPI is missing on more than 20% of the records. At least 80% of the records should have NPI.

b. Provider Type is missing on more than 20% of the records. 80% of the records should have Provider Type entered.

The following fields are 100% required on all records:

1. Claim Payer (Field #1);
2. Provider ID (Field #2);
3. Provider ID Type (Field #3);
4. Provider last Name (Field #4);
5. Provider First Name (Field #5);
6. Provider Office Address Street (Field #8);
7. Provider Office Address City (Field #9);
8. Provider Office Address State (Field #10);
9. Provider Office Address Zip (Field #11);
10. Provider Mailing Address Street (Field #12);
11. Provider Mailing Address City (Field #13);
12. Provider Mailing Address State (Field #14);
13. Provider Mailing Address zip (Field #15);
14. Provider Type (Field #16);
15. Provider Effective Date (Field #18);
16. Provider Term Date (Field #19);
17. Provider DEA Number when applicable (Field #24);
18. National Provider Identification Number (NPI) when covered under HIPAA (Field#26);

#	Field Name	Definition/Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Provider ID	Multiple formats for the same Provider ID must be avoided. For example, ID '00001111' and '001111' should be submitted with one consistent format if it indicates the same ID for the same provider.
3	Provider ID Type	A code identifying the type of ID provided in the Provider ID above. For example, 1 = NPI 6 = Internal Plan ID 8 = DEA Number (For Pharmacy claims ONLY) 9 = NABP Number (For Pharmacy claims ONLY)
4	License Number	State license number.
5	Medicaid Number	State Medicaid number (MassHealth/MMIS Provider ID). .
6	Provider Last Name	Last name of provider. In case of an organization or entity or hospital, name should be entered in this field only. Please avoid using abbreviations and enter names consistently. For example, enter "Massachusetts General Hospital" instead of "MGH". Length increased to 200 characters
7	Provider First Name	First name of the provider Please submit First Name consistently. In case of an organization or entity or hospital, name should be entered in "Provider Last Name" field above and **not** in this field. Length increased to 100 characters
8	Provider Office Address Street	Street address where services were rendered. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider
9	Provider Office Address City	City where services were rendered.
10	Provider Office Address State	State where services were rendered.
11	Provider Office Address ZIP	Zip where services were rendered. ZIP+4
12	Provider Mailing Address Street	Street address where correspondence is received. This field has to be a street address. It cannot be a post office or lock box if the provider is the billing provider
13	Provider Mailing Address City	City where correspondence is received.
14	Provider Mailing Address State	State where correspondence is received.
15	Provider Mailing Address ZIP	Zip where correspondence is received. ZIP+4
16	Provider Type	Please use the values from Table G. **Note** that value "-4" for "Incomplete/No Information" option has been removed.

Provider Data Set (cont'd)

#	Field Name	Definition/Description
17	Filler	
18	Provider Effective Date	Date provider becomes eligible to perform services.
19	Provider Term Date	Date provider is no longer eligible to perform services.
20	Provider Non-par Indicator	Non-participating provider indicator. 1 non-participating provider 2 participating provider
21	Provider Network ID	The network the provider is affiliated to by the Health Plan (internal plan ID).
22	IPA/PMG ID	The plan specific reference that identifies the Primary Medical Group (PMG) or Independent Physician Association (IPA) with which the primary care provider is associated. If the PCP is a solo practitioner, please provide the internal plan ID.
23	Panel Open Indicator	Is the provider accepting new patients? 1 Accepting new patients 2 Not accepting new patients
24	Provider DEA Number	Provider DEA Number
25	Provider Type Description	Description of the provider type
26	National Provider Identifier (NPI)	National Provider Identifier issued by the National Plan and Provider Enumeration System (NPPES). It is required on all claims.
27	Medicare ID Number	
28	Social Security Number	Provider's SSN is 9 digits field and should be entered with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.
29	NABP Number	
30	Tax ID Number	Tax ID Number is primarily the Federal Employee Identification Number (FEIN); however, when Providers don't have Tax ID Number for the reasons like being sole proprietors or small business owners without employees, provider's SSN should be entered in both fields, # 28 and #30, in same 9 digits format with no dashes (e.g.04-3333333 should be entered as 043333333 and 099-99-9999 should be entered as 099999999). Values less that 9-character long are invalid.
31	IPA/PMG ID_Type	A code identifying the type of ID provided in IPA/PMG ID Provider ID above: *Equals 6 If IPA/PMG ID is an Internal ID (Plan Specific)*

32	Gender Code	'M' for Male and 'F' for Female

Provider Data Set (cont'd)

#	Field Name	Definition/Description
33	Primary Care Eligibility Indicator	Provider is eligible to receive enhanced Medicare rate for their primary care services. This indicator should follow the CMS and MassHealth regulations on provider eligibility for Affordable Care Act – Section 1202. 0=Yes, Eligible based on 60% Attestation 1=Yes, Eligible based on Board Certification 2=No, Not Eligible 3=Unknown 4=Not Applicable **Note: The values '0' and '1' indicating provider eligibility for the "ACA Section 1202" Rate Increase should be only applicable when providers have active contracts with MCEs. If a provider contract gets terminated then the provider would no longer be eligible for the rate increase, and the value for this flag would be '2' (Not Eligible).** **The assumption is that eligible providers are either eligible based on Board Certification or 60% attestation. In the case where the MCE receives a 60% attestation from a provider that has already been determined to be eligible based on Board Certification then MCE should use value "1".**
34	APCD ORG ID	This is a new field added to get the APCD Provider Organization ID (OrgID) for the provider. Length is 6 characters. It should be submitted for all providers whose Org ID had been submitted to APCD.

3.2 MCE Internal Provider Type Data Set Elements

Data Elements

This section contains field names and definitions for the provider type record that is based on the Provider Types that are **internally** used by the MCE. This is different from MassHealth Provider Types submitted in the Provider Data Set defined above**.** ***This table should only have providers who have an internal provider type code. In other words, this table should not have providers with missing internal provider type code.***

#	Field Name	Definition/Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Provider ID	Provider ID.
3	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example, 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI
4	Internal Provider Type Code	Provider Type code as defined internally by the MCE
5	Internal Provider Type Description	Description of Provider Type code as defined internally by the MCE

3.3 Provider Specialty Data Set Elements

Data Elements

This section contains field names and definitions for the provider specialty record. If a provider has multiple specialties, please provide one record for each specialty per provider.

#	Field Name	Definition/Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Provider ID	Provider ID. Federal Tax ID, UPIN or Health Plan ID.
3	Provider Specialty	Please use the values contained in Table H. If there are provider specialties not contained in table H, assign them a new three digit number. List the description of the new values in the Provider Specialty Description field.
4	Provider Specialty Date	Date provider becomes eligible to perform specialty services.

	Field Name	Definition/Description
5	Provider ID Type	A code identifying the type of ID provided in Provider ID above: One code identifying the type of ID provided in the Provider ID above. For example: 6 = Internal ID (Plan Specific)) 8 = DEA Number 9 = NABP Number 1 = NPI
6	Provider Specialty Description	Description of the Provider Specialty

3.4 Additional Reference Data Set Elements

These files currently apply only to MBHP.

Authorization Type Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	ATHTYP	Two digit code identifying the type of service.
3	ATHTYP DESCRIPTION	Description for the ATHYTYP codes.

Claim Type Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	CLATYP	Code identifying a service.
3	CLATYP DESCRIPTION	Description for the CLATYP codes.

Group Number Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Member Rating Category	Description for the Member Rating Category.
3	DMA/DMH Indicator	Description for the DMA/DMH Indicator.
4	Eligibility Group Name	Description for the Eligibility Group Name.
5	Eligibility Group Number	Six digit number identifying the Eligibility Group.
6	MMIS Plan Type	Two digit code identifying the MMIS Eligibility Plan Type.

Service Class Data Set Elements

#	Field Name	Description
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer)
2	Service Class	Code identifying a service class.

3	Description	Description of service class codes

Services Data Set Elements

#	Field Name	Description
1	Submitter/Plan ID (Claim Payer)	Unique ID assigned to each submitting organization. (Claim Payer)
2	SVCLVLE	Description of Service Level I.
3	SVCLVLMHSA	Description of Service Level II.
4	SVCGRP	Description of Service Level III.
5	SVCDESC	Description of Service Level IV.
6	UNITTYP	Description of Unit Type.
7	UNITCONVE	Unit Conversion Value. This must be a positive number greater than zero.
8	ATHTYP	Authorization Type Code.
9	SVCCOD_REFSERVICES	Service Code.
10	CLATYP_REFSERVICES	Claim Type Code.
11	MOD1_REFSERVICES	Modifier Code.
12	ID_SERVICES	ID Services Value.
13	CBHI_FLAG	An indicator to distinguish CBHI Services
14	SERVICE_24_HOUR	Specifies if it was 24-Hour or Non-24-Hour Service (or other descriptions such as P4P)
15	IMTERMEDIATE_SVCLVLE	Specifies what kind of Intermediate Service Level was provided
16	SVCLVLI	Specifies service level provided
17	MHSAEM	Service provided: whether it was EM, or MH, or NA, or SA
18	SVCDIRECTORY	Service Directory

4.0 Encounter Record Layout

#	Field Name	H	P	L	R	D	Length	Type/Format
1	Claim Payer	X	X	X	X	X	4	N
2	Claim Category	X	X	X	X	X	1	C
3	Plan Identifier	X	X	X	X	X	9	C
4	Record Indicator	X	X	X	X	X	1	C
5	Claim Number	X	X	X	X	X	15	C
6	Claim Suffix	X	X	X	X	X	4	C
7	FILLER	X	X	X	X	X	9	C
8	Recipient DOB	X	X	X	X	X	8	D/YYYYMMDD
9	Recipient Gender	X	X	X	X	X	1	C
10	Recipient ZIP Code	X	X	X	X	X	5	N
11	Medicare Code	X	X	X	X	X	1	N
12	Other Insurance Code	X	X	X	X	X	1	C
13	FILLER	X	X	X	X	X	7	N
14	Claim Type	X	X	X	X	X	18	C
15	Admission Date	X		X			8	D/YYYYMMDD
16	Discharge Date	X		X			8	D/YYYYMMDD
17	From Service Date	X	X	X	X	X	8	D/YYYYMMDD
18	To Service Date	X	X	X		X	8	D/YYYYMMDD
19	Primary Diagnosis	X	X	X		X	7	C/ No decimal points (780.31 must be entered as 78031)
20	Secondary Diagnosis	X	X	X			7	C/ No decimal points
21	Tertiary Diagnosis	X	X	X			7	C/ No decimal points
22	Diagnosis 4	X	X	X			7	C/ No decimal points
23	Diagnosis 5	X	X	X			7	C/ No decimal points
24	Type of Admission	X		X			1	C
25	Source of Admission	X		X			1	C
26	Procedure Code	X	X	X		X	6	C
27	Procedure Modifier 1	X	X	X		X	2	C
28	Procedure Modifier 2	X	X	X		X	2	C
29	Procedure Modifier 3	X	X	X		X	2	C
30	Procedure Code Indicator	X	X	X		X	1	N
31	Revenue Code	X		X			4	C
32	Place of Service	X	X	X		X	2	C
33	Place of Service Type	X	X	X		X	2	C
34	Patient Discharge Status	X		X			2	C
35	Type of Service		X				2	C
36	Quantity	X	X	X		X	9	SN
37	NDC Number				X		11	N
38	Metric Quantity				X		9	N
39	Days Supply				X		3	N

Service Data (cont'd)

#	Field Name	H	P	L	R	D	length	type/Format
40	Refill Indicator				X		2	N
41	Dispense As Written Indicator				X		2	N
42	Dental Quadrant					X	1	N
43	Tooth Number					X	2	C
44	Tooth Surface					X	6	C
45	Paid Date	X	X	X	X	X	8	D/YYYYMMDD
46	Service Class	X	X	X	X	X	23	C
Provider Data								
47	PCP Provider ID	X	X	X		X	15	C
48	PCP Provider ID Type	X	X	X		X	1	N
49	IPA/PMG ID	X	X	X		X	15	C
50	Servicing Provider ID	X	X	X	X	X	15	C
51	Servicing Provider ID Type	X	X	X	X	X	1	N
52	Referring Provider ID	X	X	X	X	X	15	C
53	Referring Provider ID Type	X	X	X	X	X	1	N
54	Servicing Provider Class	X	X	X	X	X	1	C
55	Servicing Provider Type	X	X	X	X	X	3	N
56	Servicing Provider Specialty	X	X	X		X	3	C
57	Servicing Provider ZIP Code	X	X	X	X	X	5	N
58	Billing Provider ID	X	X	X	X	X	15	C
59	Authorization Type	X	X	X	X	X	25	C
Financial Data								
60	Billed Charge	X	X	X	X	X	9	SN
61	Gross Payment Amount	X	X	X	X	X	9	SN
62	TPL Amount	X	X	X	X	X	9	SN
63	Medicare Amount	X	X	X	X	X	9	SN
64	Copay/Coinsurance	X	X	X	X	X	9	SN
65	Deductible	X	X	X	X	X	9	SN
66	Ingredient Cost				X		9	SN
67	Dispensing Fee				X		9	SN
68	Net Payment	X	X	X	X	X	9	SN
69	Withhold Amount	X	X	X		X	9	SN
70	Record Type	X	X	X	X	X	1	C
71	Group Number	X	X	X	X	X	25	C
MassHealth Specific Data								
72	DRG	X		X			3	C
73	EPSDT Indicator		X			X	1	N
74	Family Planning Indicator	X	X		X		1	C
75	MSS/IS		X				1	N
76	New Member ID	X	X	X	X	X	25	C
Other Fields								
77	Former Claim Number	X	X	X	X	X	15	C
78	Former Claim Suffix	X	X	X	X	X	4	C
79	Record Creation Date	X	X	X	X	X	8	D
80	Service Category	X	X	X	X	X	3	C
81	Prescribing Prov. ID				X		15	C

82	Date Script Written				X		8	D/YYYYMMDD
#	Field Name	H	P	L	R	D	length	Type
83	Compound Indicator				X		1	C
84	Rebate Indicator				X		1	C
85	Admitting Diagnosis	X		X			7	C/No decimal points
86	Allowable Amount	X	X	X	X	X	9	N
87	Attending Prov. ID	X					15	C
88	Non-covered Days	X		X			3	N
89	External Injury Diagnosis 1	X		X			7	C
90	Claim Received Date				X		8	D/YYYYMMDD
91	Frequency	X		X			1	C
92	IPA/PMG ID_Type	X	X	X		X	1	N
93	Billing Provider ID _Type	X	X	X	X	X	1	N
94	Prescribing Prov. ID _Type				X		1	N
95	Attending Prov. ID _Type	X					1	N
96	Admission Time	X		X			4	N/HH24MI
97	Discharge Time	X		X			4	N/HH24MI
98	Diagnosis 6	X	X	X			7	C/No decimal points
99	Diagnosis 7	X	X	X			7	C/No decimal points
100	Diagnosis 8	X	X	X			7	C/No decimal points
101	Diagnosis 9	X	X	X			7	C/No decimal points
102	Diagnosis 10	X	X	X			7	C/No decimal points
103	Surgical Procedure code 1	X					7	C
104	Surgical Procedure code 2	X					7	C
105	Surgical Procedure code 3	X					7	C
106	Surgical Procedure code 4	X					7	C
107	Surgical Procedure code 5	X					7	C
108	Surgical Procedure code 6	X					7	C
109	Surgical Procedure code 7	X					7	C
110	Surgical Procedure code 8	X					7	C
111	Surgical Procedure code 9	X					7	C
112	Employment	X	X	X	X	X	1	C
113	Auto Accident	X	X	X	X	X	1	C
114	Other Accident	X	X	X	X	X	1	C
115	Total Charges	X	X	X	X	X	9	N
116	Non Covered charges	X	X	X	X	X	9	N
117	Coinsurance	X	X	X	X	X	9	N
118	Void Reason Code	X	X	X	X	X	1	C
119	DRG Description	X		X			132	C
120	DRG Type	X		X			1	C
121	DRG Version	X		X			3	C/ No decimal points (26.1 must be entered as 261)
122	DRG Severity of Illness Level	X		X			1	C
123	DRG Risk of Mortality Level	X		X			1	C
124	Patient Pay Amount	X		X			9	SN
125	Patient Reason for Visit Diagnosis 1	X		X			7	C/No decimal points

#	Field Name	H	P	L	R	D	length	Type
126	Patient Reason for Visit Diagnosis 2	X		X			7	C/No decimal points
127	Patient Reason for Visit Diagnosis 3	X		X			7	C/No decimal points
128	Present on Admission (POA) 1	X		X			1	C
129	Present on Admission (POA) 2	X		X			1	C
130	Present on Admission (POA) 3	X		X			1	C
131	Present on Admission (POA) 4	X		X			1	C
132	Present on Admission (POA) 5	X		X			1	C
133	Present on Admission (POA) 6	X		X			1	C
134	Present on Admission (POA) 7	X		X			1	C
135	Present on Admission (POA) 8	X		X			1	C
136	Present on Admission (POA) 9	X		X			1	C
137	Present on Admission (POA) 10	X		X			1	C
138	Diagnosis 11	X	X	X			7	C/No decimal points
139	Present on Admission (POA) 11	X		X			1	C
140	Diagnosis 12	X	X	X			7	C/No decimal points
141	Present on Admission (POA) 12	X		X			1	C
142	Diagnosis 13	X		X			7	C/No decimal points
143	Present on Admission (POA) 13	X		X			1	C
144	Diagnosis 14	X		X			7	C/No decimal points
145	Present on Admission (POA) 14	X		X			1	C
146	Diagnosis 15	X		X			7	C/No decimal points
147	Present on Admission (POA) 15	X		X			1	C
148	Diagnosis 16	X		X			7	C/No decimal points
149	Present on Admission (POA) 16	X		X			1	C
150	Diagnosis 17	X		X			7	C/No decimal points
151	Present on Admission (POA) 17	X		X			1	C
152	Diagnosis 18	X		X			7	C/No decimal points
153	Present on Admission (POA) 18	X		X			1	C
154	Diagnosis 19	X		X			7	C/No decimal points
155	Present on Admission (POA) 19	X		X			1	C
156	Diagnosis 20	X		X			7	C/No decimal points
157	Present on Admission (POA) 20	X		X			1	C
158	Diagnosis 21	X		X			7	C/No decimal points
159	Present on Admission (POA) 21	X		X			1	C
160	Diagnosis 22	X		X			7	C/No decimal points
161	Present on Admission (POA) 22	X		X			1	C
162	Diagnosis 23	X		X			7	C/No decimal points
163	Present on Admission (POA) 23	X		X			1	C
164	Diagnosis 24	X		X			7	C
165	Present on Admission (POA) 24	X		X			1	C
166	Diagnosis 25	X		X			7	C/No decimal points
167	Present on Admission (POA) 25	X		X			1	C
168	Diagnosis 26	X		X			7	C/No decimal points

#	Field Name	H	P	L	R	D	length	Type
169	Present on Admission (POA) 26	X		X			1	C
170	Present on Admission (POA) EI 1	X		X			1	C
171	External Injury Diagnosis 2	X		X			7	C/No decimal points
172	Present on Admission (POA) EI 2	X		X			1	C
173	External Injury Diagnosis 3	X		X			7	C/No decimal points
174	Present on Admission (POA) EI 3	X		X			1	C
175	External Injury Diagnosis 4	X		X			7	C/No decimal points
176	Present on Admission (POA) EI 4	X		X			1	C
177	External Injury Diagnosis 5	X		X			7	C/No decimal points
178	Present on Admission (POA) EI 5	X		X			1	C
179	External Injury Diagnosis 6	X		X			7	C/No decimal points
180	Present on Admission (POA) EI 6	X		X			1	C
181	External Injury Diagnosis 7	X		X			7	C/No decimal points
182	Present on Admission (POA) EI 7	X		X			1	C
183	External Injury Diagnosis 8	X		X			7	C/No decimal points
184	Present on Admission (POA) EI 8	X		X			1	C
185	External Injury Diagnosis 9	X		X			7	C/No decimal points
186	Present on Admission (POA) EI 9	X		X			1	C
187	External Injury Diagnosis 10	X		X			7	C/No decimal points
188	Present on Admission (POA) EI 10	X		X			1	C
189	External Injury Diagnosis 11	X		X			7	C/No decimal points
190	Present on Admission (POA) EI 11	X		X			1	C
191	External Injury Diagnosis 12	X		X			7	C/No decimal points
192	Present on Admission (POA) EI 12	X		X			1	C
193	ICD Version Qualifier	X	X	X		X	5	C
194	Procedure Modifier 4	X	X	X		X	2	C
195	Service Category Type	X	X	X	X	X	3	C
196	Ambulance Patient Count		X				3	N
197	Obstetric Unit Anesthesia Count		X				5	N
198	Prescription Number				X		15	C
199	Taxonomy Code	X	X	X		X	10	C
200	Rate Increase Indicator	X	X	X			1	C
201	Bundle Indicator	X	X	X	X	X	1	C
202	Bundle Claim Number	X	X	X	X	X	15	C
203	Bundle Claim Suffix	X	X	X	X	X	4	C

4.1 Provider Record Layout

#	Field Name	length	type
1	Submitter/Plan ID (Claim Payer)	9	C
2	Provider ID	15	C
3	ID Type	1	C
4	State License Number	9	C
5	Medicaid Number	10	C
6	Provider Last Name	200	C
7	Provider First Name	100	C
8	Provider Office Address Street	45	C
9	Provider Office Address City	20	C
10	Provider Office Address State	2	C
11	Provider Office Address ZIP	9	C
12	Provider Mailing Address Street	45	C
13	Provider Mailing Address City	20	C
14	Provider Mailing Address State	2	C
15	Provider Mailing Address ZIP	9	C
16	Provider Type	3	N
17	Filler	3	C
18	Provider Effective Date	8	D
19	Provider Term Date	8	D
20	Provider Non-par Indicator	1	C
21	Provider Network ID	15	C
22	IPA/PMG ID	15	C
23	Panel Open Indicator	1	C
24	Provider DEA Number	11	C
25	Provider Type Description	50	C
26	National Provider Identifier (NPI)	10	C
27	Medicare ID Number	15	C
28	Social Security Number	9	C
29	NAPB Number	9	C
30	Tax ID	9	C
31	IPA/PMG ID Type	1	C
32	Gender Code	1	C
33	Primary Care Eligibility Indicator	1	C
34	APCD ORG ID	6	C

4.2 MCE Internal Provider Type Layout

#	Field Name	length	type
1	Submitter/Plan ID (Claim Payer)	9	C
2	Provider ID	15	C
3	Provider ID Type	1	C
4	Internal Provider Type Code	6	C
5	Internal Provider Type Description	120	C

4.3 Provider Specialty Layout

#	Field Name	length	type
1	Submitter/Plan ID (Claim Payer)	9	C
2	Provider ID	15	C
3	Provider Specialty	3	C
4	Provider Specialty Date	8	D
5	Provider ID Type	1	C
6	Provider Specialty Description	50	C

4.4 Amendment Process and Layout

1. There are no constraints on timing of the submission of amendment feeds. We will be able to handle amendments sent as part of a regular submission in a quarterly/monthly cycle or as one-off submissions outside the schedule. The format of this file is the same as the Encounter Data file. All columns should represent the "after-snap-shot" – i.e. data should be post-changes. This feed should be submitted with the standard metadata file.

2. Record type 'A' is used to identify an amendment record. While the record type of an amendment record will be 'A', it will inherit the record type of the record it is amending when it is inserted into our database.

3. Amendment processing has been created to allow MCEs to make retroactive changes to existing claims. By existing claims, we mean those that have been accepted by MassHealth after they either passed the weeding logic or were manually overridden.

4. Dollar amount changes on the claim happening on the source system – like adjustments, voids – should still be handled via existing process set up to handle those kinds of transactions.

5. Amendment claims must be submitted in a format that reflects the current processing logic. A claim submitted prior to the introduction of Commonwealth Care, when amended must have valid data in the Group Number field. In addition, all provider data must point to the current provider reference data.

6. We expect that this will primarily be used to reflect retroactive dimension changes – such as Member ID, Servicing Category etc. If MCEs have issues with constructing original claim, they can send MassHealth a list of claim number/suffixes and we can send a copy of the latest version of the data for that claim as exists in our data-warehouse -- back to the MCE.

7. The primary key for the amendment file will be the combination of claim number/suffix and former claim number/suffix. This combination must exist in our encounter database. If the claim number + claim suffix of the 'A' record is not found in our database, the record will be rejected with error code 11--Active Original Claim No-Claim Suffix Not Found.

8. Multiple amendments to the same record in the same feed will not be allowed and will be rejected with error code 10--Duplicate Claim No-Claim Suffix -- in same feed.

9. The amendment process will have the same iterative error process as the regular submission.

4.5 Additional Reference Data Layout

These files currently apply only to MBHP

Authorization Type Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	ATHTYP	6	C
3	DESCRIPTION	100	C

Claim Type Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	CLATYP	6	C
3	DESCRIPTION	100	C

Group Number Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	Member Rating Category	50	C
3	DMA/DMH Indicator	50	C
4	Eligibility Group Name	100	C
5	Eligibility Group Number	10	N
6	MMIS Plan Type	2	C

Service Class Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	Service Class	10	C
3	Description	100	C

Additional Reference Data Layout (cont'd):

Services Data Set Layout

#	Field Name	length	type
1	Claim Payer	4	C
2	SVCLVLE	60	C
3	SVCLVLMHSA	90	C
4	SVCGRP	100	C
5	SVCDESC	120	C
6	UNITTYP	4	C
7	UNITCONVE	12	N
8	ATHTYP	1	C
9	SVCCOD_REFSERVICES	6	C
10	CLATYP_REFSERVICES	2	C
11	MOD1_REFSERVICES	2	C
12	ID_SERVICES	10	N
13	CBHI_FLAG	10	C
14	SERVICE_24_HOUR	11	C
15	IMTERMEDIATE_SVCLVLE	50	C
16	SVCLVLI	60	C
17	MHSAEM	2	C
18	SVCDIRECTORY	82	C

* **Key to Data Types**

C Character

Includes space, A-Z (upper or lower case), 0-9

Left justified with trailing blanks.

Unrecorded or missing values are blank

N Numeric

Include 0-9.

Right justified, lead-zero filled.

Unrecorded or missing values are blank

D Date Fields

Dates should be in a numeric format. The format for all dates is eight digits in YYYYMMDD format, where YYYY represents a four digit year, MM = numeric month indicator (01 - 12); DD = numeric day indicator (01 - 31).

For example: November 22, 1963 = 19631122

Financial Fields

MassHealth prefers to receive both dollars and cents, with an **implied decimal point** before the last two digits in the data.

For example, the data string "1234567" would represent $12,345.67

Please do not include the actual decimal point in the data.

H – Facility (Inpatient and Outpatient Hospital); P – Professional and Other Providers (including vision); L – Long Term Care, residential treatment Facility; R – Prescription drug; D - Dental

5.0 Error Handling

MassHealth will validate the feeds received from the MCEs and MBHP and return files containing erroneous records back to the MCEs and MBHP for correction and resubmission. The error rate in the initial submission should be no more than 3% for the data to be considered complete and accurate. The format of the error files will be the same as the input record layout described above with 2 fields appended as the last 2 fields on the record layout. These will be the erroneous field number and the error code for that field. Section 8.0 Quantity & Quality Edits lays out the expectation for each field in the record format for the feed. In addition to these edits, MassHealth will also subject the records to some intra-record validation tests. These may include validation checks like "net amount <= gross amount", "non-unique claim number + claim suffix combination", etc. Error checking is likely to evolve with time therefore a complete list of all pseudo-columns and error codes will accompany the rejected records returned to the MCEs and MBHP. A list is published below.

Error Codes

Error Code	Description
1	Incorrect Data Type
2	Invalid Format
3	Missing value
4	Code missing from reference data
5	Invalid Date.
6	Admissions Date is greater than Discharge Date
7	Discharge Date is less than Admissions Date
8	Paid Date is less than Admission or Discharge or Service Dates
9	Date is prior to Birth Date
10	Duplicate Claim No-Claim Suffix -- in same feed
11	Active Original Claim No-Claim Suffix Not Found
12	Bad Zip Code
13	Replacement received for a voided record
14	Date is in the future
15	From Service Date is greater than To Service Date
16	To Service Date is less than From Service Date
17	Cannot be Negative
18	Non HIPAA/Standard code.
19	Bad Metadata File.
20	Local Code Not present in MassHealth DW.
21	Cannot be Zero.
22	Former Claim No-Claim Suffix fields should not contain data for Original Claim
23	Only Original claims allowed in the Initial feed
24	Duplicate Claim No-Claim Suffix -- from prior submission
25	Filler
26	Original Claim No-Claim Suffix, Former Claim No-Claim Suffix -- in same feed

Error Codes (cont'd):

Error Code	Description
27	Metadata - No metadata file found or file is empty.
28	Metadata - MCE_Id incorrect for the plan.
29	Metadata - MCE_ID not found in metadata file.
30	Metadata - Date_Created not found in metadata file.
31	Metadata - Date_Created is not a valid date.
32	Metadata - Data_File_Name not found in metadata file.
33	Metadata - Data_File_Name does not exist or is not a regular file.
34	Metadata - Pro_file_Name not found in metadata file.
35	Metadata - Pro_file_Name does not exist or is not a regular file.
36	Metadata - Pro_Spec_Name not found in metadata file.
37	Metadata - Pro_Spec_Name does not exist or is not a regular file.
38	Metadata - Total_Records not found in metadata file.
39	Metadata - Total_Records does not match actual record count.
40	Metadata - Total_Net_Payments not found in metadata file.
41	Metadata - Total_Net_Payments does not match actual sum of dollar amount.
42	Metadata - Time_Period_From not found in metadata file.
43	Metadata - Time_Period_From is not a valid date.
44	Metadata - Time_Period_To not found in metadata file.
45	Metadata - Time_Period_To is not a valid date.
46	Metadata - Return_To not found in metadata file.
47	Metadata - Type_Of_Feed not found in metadata file.
48	Metadata - Type_Of_Feed contains invalid value. Refer to the spec for valid values.
49	Metadata - Metadata - Ref_Services_File_Name not found in metadata file.
50	Metadata - Ref_Services_File_Name does not exist or is not a regular file.
51	Metadata - ATHTYP_File_Name not found in metadata file.
52	Metadata - ATHTYP_File_Name does not exist or is not a regular file.
53	Metadata - GRPNUM_File_Name not found in metadata file.
54	Metadata - GRPNUM_File_Name does not exist or is not a regular file.
55	Metadata - SVCCLS_File_Name not found in metadata file.
56	Metadata - SVCCLS_File_Name does not exist or is not a regular file.
57	Metadata - CLATYP_File_Name not found in metadata file.
58	Metadata - CLATYP_File_Name does not exist or is not a regular file.
59	RefService not found.
60	If former claim number filled in, so must former_claim_suffix.
70	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (To Service Date >=10/01/2015)
71	ICD Version Qualifier ICD9 used on a claim post ICD10 implementation (Discharge Date>=10/01/2015)
61	*Missing Provider NPI – Not used at present*
62	Metadata - Pro_MCEType_Name not found in metadata file.
63	Metadata - Pro_MCEType_Name does not exist or is not a regular file.

The MCEs and MBHP shall resubmit corrected records within a week of receiving the error files from MassHealth. This process will be repeated until the number of validation errors falls below a MassHealth defined threshold for each MCE. Refer to the “Encounter Data” section in the MassHealth Managed Care Organization Contract, for more details on the action required when data submission is not in compliance with Encounter Data requirements.

6.0 Media Requirements

Format

File Type: PKZIP/WINZIP compressed plain text file
Character Set: ASCII

All submitted files should be ***pipe-delimited.*** Please compress the data file using PKZIP/WINZIP or compatible program. All records in the data file should follow the record layout specified in section 4.0 where the length represents the maximum length of each field. Padding fields with 0s or spaces is ***not*** required.

Each record should end with the standard MS Windows text file end-of-line marker ("\r\n" - a carriage control followed by a new line).

Filename

The Zip file name should conform to the following naming convention:

PPP_Claims_YYYYMMDD.zip

Where "YYYYMMDD" is the date of file creation (4 digit year, 2 digit month, 2 digit day) and PPP identifies the MCE according to the following:

MCOs:
BMC - Boston Medical Center HealthNet Plan
CHA - Cambridge Network Health
FLN- Fallon Community Health Plan
MBH - Massachusetts Behavioral Health Partnership
NHP - Neighborhood Health Plan
HNE - Health New England
CAR - CeltiCare

SCOs:
CCA - Commonwealth Care Alliance
UHC – United Health Care
NAV - Navicare
SWH - Senior Whole Health
TFT – Tufts Health Plan
BHP – BMC HealthNet Plan

One Care (ICO):
CCI - Commonwealth Care Alliance
NWI – Cambridge Network Health
FTC – Fallon Total Care

For example, the Boston Medical Center HealthNet Plan submission created on 7/1/2001 would have the name BMC_Claims_20010701.zip

The Manual Override File

The manual override file should be named PPP_Claims_YYYYMMDD_MO. The _MO files should be sent only after the error file has been returned to the MCEs and the MCEs have re-submitted a corrected file. The manual override file should have a file type of EMO in the metadata file.

The Zip File should contain:

The Encounter Data file
The Provider data file
The Provider specialty file
The MCE Internal Provider Type file
The Manual Override file (if applicable)
The Service Reference file (MBHP Only)
The Service Class Codes file (MBHP Only)
The Authorization Type Codes file (MBHP Only)
The Claim Type Codes file (MBHP Only)
The Group Number Codes file (MBHP Only)

Additional Documentation File or Metadata file

Metadata file

Please submit an additional file called **metadata.txt** which contains the following Key Value Pairs. A regular submission or error submission file should have a file type of ENC. The manual override file should have a file type of EMO in the metadata file.

	ENC/EMO
MCE_Id="Value" (MCO: FLN,NHP,BMC,CHA,MBH,HNE,CAR) (SCO: CCA, UHC, NAV, SWH, TFT, BHP) (One Care-ICO: CCI, NWI, FTC)	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Data_File_Name="Value"	Mandatory
Pro_File_Name="Value"	Mandatory
Pro_Spec_Name="Value"	Mandatory
Pro_MCEType_Name=”Value”	Mandatory
Total_Records="Value"	Mandatory
Total_Net_Payments="Value"	Mandatory
Time_Period_From="Value" (YYYYMMDD)	Mandatory
Time_Period_To="Value" (YYYYMMDD)	Mandatory
Return_To="email address"	Mandatory
Type_Of_Feed="Value" (ENC/EMO)	Mandatory
Ref_Services_File_Name ="Value"	Optional

SVCCLS_File_Name ="Value"	Optional
ATHTYP_File_Name ="Value"	Optional
CLATYP_File_Name ="Value"	Optional
GRPNUM_File_Name ="Value"	Optional

a) Files in the metadata file must match actual files in the archive in case and extension.
b) Send a zero byte None.txt for missing files - provider or specialty and set corresponding field value to "None.txt"
c) Make sure that archive file sent down each time has a unique name - this is because -- if the job that we will run to pick up the files -- does not run on a day for some reason, there is a risk of losing the original file.
d) Discrepancy between actual feed and Metadata file fields: Total_Net_Payments and or Total_Records would result in entire feed being rejected.
e) The key in the key-value pair (example Total_Net_Payments) must match in spelling to what is on the spec.
f) From a processing perspective there is no difference between the original submission, an error file, or an Amendment file. All these types of submissions should use ENC as the type of feed.

Monthly Financial Report

This is a stand-alone text file submitted monthly separate from encounter data submission; however, it must be always submitted ***after*** the manual override file. Please follow instructions in Section 1.1 "Data Requirements".

Monthly Financial Report is submitted as a pipe-delimited text file based on the following specifications:

1. File name should conform to the following naming convention: **MCE_FinReport_YYYYMMDD.txt** where the date reflects the date of a file submission.

   Example:
   A report submitted by Boston Medical Center HealthNet Plan in May of 2015 for the month of March of 2015 would be named: **BMC_FinReport_20150531.txt**

2. Along with the report file, a confirmation file named **"mce_fin_done.txt"** should be submitted. This file should contain one field only indicating the name of the financial report submitted.

   Example:
   mce_fin_done.txt submitted along with **BMC_FinReport_20150531.txt** file will have the following content:
   "MCE_FINREP_FILE="BMC_FinReport_20150531.txt"

   First report record is a mandatory header record with the following details:
   MCE_ID|Reporting_YearMonth|Date_Created|Total_Records|Return_To

   Example:

   BMC|201503|20150531|25|abc.xyz@bmchp.org

3. Definition of header record by data element:

#	Field Name	Definition
1	MCE_ID	One of the following values: MCO: FLN,NHP,BMC,CHA,MBH,HNE,CAR; SCO: CCA, UHC, NAV, SWH, TFT, BHP; One Care-ICO: CCI, NWI, FTC.
2	Reporting_YearMonth	Must be the year and the month of the reporting month in "YYYYMM" format. (Same as "YearMonth" in the report).
3	Date_Created	Must be the date of submission with format "YYYYMMDD"
4	Total_Records	Number of records in the report excluding the header record.
5	Return_To	Must have the email address of the MCE contact person(s).

4. Data records should follow the header record with the layout described below:

#	Field Name	Definition	Length	Type
1	Claim Payer	Unique ID assigned to each submitting organization. (Claim Payer).	4	Text
2	Service Category	Service Category as defined in Tables I-A, I-B, I-C	3	Text
3	Description	Description of Service Category	120	Text
4	Total_Number_Of_Claim_Lines	Total number of claim lines per Service Category	10	Number
5	Total Net Payment	Total expenses per Service Category	15	*Number/No Decimal Point
6	YearMonth	The Year and Month of the report based on the dates of service on the claims. There is only one value per monthly report. See example below for August 2014 report.	6	Text

*****MassHealth prefers to receive dollars and cents with an **implied decimal point** before the last two digits in the data. Actual decimal point must not be included in dollar amounts.

For example, a data string "1234567" would represent $12,345.67.

Report Example:

BMC|201503|20150531|25|abc.xyz@bmchp.org
997|5|Behavioral Health - Emergency Services|148|12365400|201408
997|9|Facility - Medical/Surgical|321|987456|201408
997|13|Laboratory|654|321456|201408
…….

Note: No Pipes are allowed in the values of any above mentioned elements

Secure FTP Server

MassHealth has set up a Secure FTP server for exchanging data with the MCEs. Please follow procedures in SecFTPClient_guide.doc for setting up the client. Details of the server are below:

Sever: virtualgateway01.ehs.state.ma.us
ID currently set up for MCOs: fln, nhp, bmc, cha, mbhp, gu02, gu04.
ID currently set up for SCOs: swh, uhc, nav, cca, tft, bhp.
ID currently set up for One Care (ICOs): cci, nwi, ftc.
Home directory: /home/<mce>: example /home/nhp.
Each home directory contains following sub directories:

- *ehs_dw* : production folder for exchanging encounter data and error reports.
- *test_masshealth*: used by MassHealth for testing purpose.
- *test_mco* : available for mce to send any test files or adhoc data to MassHealth.

Sending Encounter data

Transfer encounter data with format and content as described in sections above - to the production folder on the server. After the data transfer is complete, include a zero byte file called *mce_done.txt.* Please refrain from sending file with the same name more than once to the server.

Receiving Error reports

After the data has been processed, an error zip file (beginning with err) will be posted to the production folder. A notification email will be sent to the email address provided in the Metadata feed. Please note that the error file will be available on the server for a period of 30 days. MassHealth may need to revise the retention period in the future, based on available disk space on the server. If you post a file and do not receive email message about the error file back in 7 business days, please contact MassHealth.

CMS Internet Security Policy

DATE OF ISSUANCE: November 24, 1998

SUBJECT:

Internet Communications Security and Appropriate Use Policy and Guidelines for CMS Privacy Act-protected and other Sensitive CMS Information.

1. Purpose.

This bulletin formalizes the policy and guidelines for the security and appropriate use of the Internet to transmit CMS Privacy Act-protected and other sensitive CMS information.

2. Effective Date.

This bulletin is effective as of the date of issuance.

3. Expiration Date.

This bulletin remains in effect until superseded or canceled.

4. Introduction.

The Internet is the fastest growing telecommunications medium in our history. This growth and the easy access it affords has significantly enhanced the opportunity to use advanced information technology for both the public and private sectors. It provides unprecedented opportunities for interaction and data sharing among health care providers, CMS contractors, CMS components, State agencies acting as CMS agents, Medicare and Medicaid beneficiaries, and researchers. However, the advantages provided by the Internet come with a significantly greater element of risk to the confidentiality and integrity of information. The very nature of the Internet communication mechanisms means that security risks cannot be totally eliminated. Up to now, because of these security risks and the need to research security requirements vis-a-vis the Internet, CMS has prohibited the use of the Internet for the transmission of all CMS Privacy Act-protected and other sensitive CMS information by its components and Medicare/Medicaid partners, as well as other entities authorized to use this data.

The Privacy Act of 1974 mandates that federal information systems must protect the confidentiality of individually-identifiable data. Section 5 U.S.C. 552a (e) (10) of the Act is very clear; federal systems must: "...establish appropriate administrative, technical, and physical safeguards to insure the security and confidentiality of records and to protect against any anticipated threats or hazards to their security or integrity which could result in substantial harm, embarrassment, inconvenience, or unfairness to any individual on whom information is maintained." One of CMS's primary responsibilities is to assure the security of the Privacy Act-protected and other sensitive information it collects, produces, and disseminates in the course of conducting its operations. CMS views this responsibility as a covenant with its beneficiaries, personnel, and health care providers. This responsibility is also assumed by CMS's contractors, State agencies acting as CMS agents, other government organizations, as well as any entity that has been authorized access to CMS information resources as a party to a Data Release Agreement with CMS.

However, CMS is also aware that there is a growing demand for use of the Internet for inexpensive transmission of Privacy Act-protected and other sensitive information. CMS has a responsibility to accommodate this desire as long as it can be assured that proper steps are being taken to maintain an acceptable level of security for the information involved.

This issuance is intended to establish the basic security requirements that must be addressed for use of the Internet to transmit CMS Privacy Act-protected and/or other sensitive CMS information.

The term "CMS Privacy Act-protected Data and other sensitive CMS information" is used throughout this document. This phrase refers to data which, if disclosed, could result in harm to the agency or individual persons. Examples include:

All individually identifiable data held in systems of records. Also included are automated systems of records subject to the Privacy Act, which contain information that meets the qualifications for Exemption 6 of the Freedom of Information Act; i.e., for which unauthorized disclosure would constitute a "clearly unwarranted invasion of personal privacy" likely to lead to specific detrimental consequences for the individual in terms of financial, employment, medical, psychological, or social standing.

Payment information that is used to authorize or make cash payments to individuals or organizations. These data are usually stored in production application files and systems, and include benefits information, such as that found at the Social Security Administration (SSA), and payroll information. Such information also includes databases that the user has the authority and capability to use and/or alter. As modification of such records could cause an improper payment, these records must be adequately protected.

Proprietary information that has value in and of itself and which must be protected from unauthorized disclosure.

Computerized correspondence and documents that are considered highly sensitive and/or critical to an organization and which must be protected from unauthorized alteration and/or premature disclosure.

5. Policy

This Guide establishes the fundamental rules and systems security requirements for the use of the Internet to transmit CMS Privacy Act-protected and other sensitive CMS information collected, maintained, and disseminated by CMS, its contractors, and agents.

It is permissible to use the Internet for transmission of CMS Privacy Act-protected and/or other sensitive CMS information, as long as an acceptable method of encryption is utilized to provide for confidentiality and integrity of this data, and that authentication or identification procedures are employed to assure that both the sender and recipient of the data are known to each other and are authorized to receive and decrypt such information. Detailed guidance is provided below in item 7.

6. Scope.

This policy covers all systems or processes which use the Internet, or interface with the Internet, to transmit CMS Privacy Act-protected and/or other sensitive CMS information, including Virtual Private Network (VPN) and tunneling implementations over the Internet. Non-Internet Medicare/Medicaid data communications processes (e.g., use of private or value added networks) are not changed or affected by the Internet Policy.

This policy covers Internet data transmission only. It does not cover local data-at-rest or local host or network protections. Sensitive data-at-rest must still be protected by all necessary measures, in conformity with the guidelines/rules which govern the entity's possession of the data. Entities must use due diligence in exercising this responsibility.

Local site networks must also be protected against attack and penetration from the Internet with the use of firewalls and other protections. Such protective measures are outside the scope of this document, but are essential to providing adequate local security for data and the local networks and ADP systems which support it.

7. Acceptable Methods

CMS Privacy Act-protected and/or other sensitive CMS information sent over the Internet must be accessed only by authorized parties. Technologies that allow users to prove they are who they say they are (authentication or identification) and the organized scrambling of data (encryption) to avoid inappropriate disclosure or modification must be used to insure that data travels safely over the Internet and is only disclosed to authorized parties. Encryption must be at a sufficient level of security to protect against the cipher being readily broken and the data compromised. The length of the key and the quality of the encryption framework and algorithm must be increased over time as new weaknesses are discovered and processing power increases.

User authentication or identification must be coupled with the encryption and data transmission processes to be certain that confidential data is delivered only to authorized parties. There are a number of effective means for authentication or identification which are sufficiently trustworthy to be used, including both in-band authentication and out-of-band identification methods. Passwords may be sent over the Internet only when encrypted.

(footnote)1 We note that the Health Insurance Portability and Accountability Act of 1966 (HIPAA) calls for stringent security protection for electronic health information both while maintained and while in transmission. The proposed Security Standard called for by HIPAA was published in the Federal Register on August 12, 1998. The public had until October 13, 1998, to comment on the proposed regulation. Based on public comments, a final regulation is planned for late 1999. Policy guidance contained in this bulletin is consistent with the proposed HIPAA security requirements.

ENCRYPTION MODELS AND APPROACHES

Figure 1 depicts three generalized configurations of connectivity to the Internet. The generic model is not intended to be a literal mirror of the actual Internet interface configuration, but is intended to show that the encryption process takes place prior to information being presented to the Internet for transmission, and the decryption process after reception from the Internet. A large organization would be very likely to have the Internet Server/Gateway on their premises while a small organization would likely have only the Internet Client, e.g., a browser, on premises with the Internet Server at an Internet Service Provider (ISP). The Small User and Large User examples offer a more detailed depiction of the functional relationships involved.

The Encryption/Decryption process depicted graphically represents a number of different approaches. This process could involve encryption of files prior to transmittal, or it could be implemented through hardware or software functionality. The diagram does not intend to dictate how the process is to be accomplished, only that it must take place prior to introduction to the Internet. The "Boundary" on the diagrams represents the point at which security control passes from the local user. It lies on the user side of the Internet Server and may be at a local site or at an Internet Service Provider depending upon the configuration.

FIGURE 1: INTERNET COMMUNICATIONS EXAMPLES in PDF.

Acceptable Approaches to Internet Usage

The method(s) employed by all users of CMS Privacy Act-protected and/or other sensitive CMS information must come under one of the approaches to encryption and at least one of the authentication or identification approaches. The use of multiple authentication or identification approaches is also permissible. These approaches are as generic as possible and as open to specific implementations as possible, to provide maximum user flexibility within the allowable limits of security and manageability.

Note the distinction that is made between the processes of "authentication" and "identification". In this Internet Policy, the terms "Authentication" and "Identification" are used in the following sense. They should not be interpreted as terms of art from any other source. Authentication refers to generally automated and formalized methods of establishing the authorized nature of a communications partner over the Internet communications data channel itself, generally called an "in-band process." Identification refers to less formal methods of establishing the authorized nature of a communications partner, which are usually manual, involve human interaction, and do not use the Internet data channel itself, but another "out-of-band" path such as the telephone or US mail.

The listed approaches provide encryption and authentication/identification techniques which are acceptable for use in safeguarding CMS Privacy Act-protected and/or other sensitive CMS information when it is transmitted over the Internet.

In summary, a complete Internet communications implementation must include adequate encryption, employment of authentication or identification of communications partners, and a management scheme to incorporate effective password/key management systems.

ACCEPTABLE ENCRYPTION APPROACHES

Note: As of November 1998, a level of encryption protection equivalent to that provided by an algorithm such as Triple 56 bit DES (defined as 112 bit equivalent) for symmetric encryption, 1024 bit algorithms for asymmetric systems, and 160 bits for the emerging Elliptical Curve systems is recognized by CMS as minimally acceptable. CMS reserves the right to increase these minimum levels when deemed necessary by advances in techniques and capabilities associated with the processes used by attackers to break encryption (for example, a brute-force exhaustive search).

HARDWARE-BASED ENCRYPTION:

1. Hardware encryptors - While likely to be reserved for the largest traffic volumes to a very limited number of Internet sites, such symmetric password "private" key devices (such as link encryptors) are acceptable.

SOFTWARE-BASED ENCRYPTION:

2. Secure Sockets Layer (SSL) (Sometimes referred to as Transport Layer Security - TLS) implementations - At a minimum SSL level of Version 3.0, standard commercial implementations of PKI, or some variation thereof, implemented in the Secure Sockets Layer are acceptable.

3. S-MIME - Standard commercial implementations of encryption in the e-mail layer are acceptable.

4. In-stream - Encryption implementations in the transport layer, such as pre-agreed passwords, are acceptable.

5. Offline - Encryption/decryption of files at the user sites before entering the data communications process is acceptable. These encrypted files would then be attached to or enveloped (tunneled) within an unencrypted header and/or transmission.

ACCEPTABLE AUTHENTICATION APPROACHES

AUTHENTICATION (This function is accomplished over the Internet, and is referred to as an "in-band" process.)

1. Formal Certificate Authority-based use of digital certificates is acceptable.

2. Locally-managed digital certificates are acceptable, providing all parties to the communication are covered by the certificates.

3. Self-authentication, as in internal control of symmetric "private" keys, is acceptable.

4. Tokens or "smart cards" are acceptable for authentication. In-band tokens involve overall network control of the token database for all parties.

ACCEPTABLE IDENTIFICATION APPROACHES

IDENTIFICATION (The process of identification takes place outside of the Internet connection and is referred to as an "out-of-band" process.)

1. Telephonic identification of users and/or password exchange is acceptable.

2. Exchange of passwords and identities by U.S. Certified Mail is acceptable.

3. Exchange of passwords and identities by bonded messenger is acceptable.

4. Direct personal contact exchange of passwords and identities between users is acceptable.

5. Tokens or "smart cards" are acceptable for identification. Out-of-band tokens involve local control of the token databases with the local authenticated server vouching for specific local users.

8. REQUIREMENTS AND AUDITS

Each organization that uses the Internet to transmit CMS Privacy Act-protected and/or other sensitive CMS information will be expected to meet the stated requirements set forth in this document.

All organizations subject to OMB Circular A-130 are required to have a Security Plan. All such organizations must modify their Security Plan to detail the methodologies and protective measures if they decide to use the Internet for transmittal of CMS Privacy Act-protected and/or other sensitive CMS information, and to adequately test implemented measures.

CMS reserves the right to audit any organization's implementation of, and/or adherence to the requirements, as stated in this policy. This includes the right to require that any organization utilizing the Internet for transmission of CMS Privacy Act-protected and/or other sensitive information submit documentation to demonstrate that they meet these requirements.

9. ACKNOWLEDGMENT OF INTENT

Organizations desiring to use the Internet for transmittal of CMS Privacy Act-protected and/or other sensitive CMS information must notify CMS of this intent. An e-mail address is provided below to be used for this acknowledgment. An acknowledgment must include the following information:

Name of Organization
Address of Organization
Type/Nature of Information being transmitted
Name of Contact (e.g., CIO or an accountable official)
Contact's telephone number and e-mail address

For submission of acknowledgment of intent, send an e-mail to: internetsecurity@CMS.gov.
Internal
CMS elements must proceed through the usual CMS system and project development process.

10. POINT OF CONTACT

For questions or comment, write to:

Office of Information Services, CMS
Security and Standards Group
Division of CMS Enterprise Standards -Internet

7500 Security Boulevard
Baltimore, MD 21244

Also, check out the Security Policy FAQs

Return to Information Clearinghouse Listing

Last Updated January 31, 2001

7.0 Standard Data Values

Contents

This section contains tables that identify the standard coding structures for several of the encounter data fields.

Use of Standard Data Values

The tables list all of the standard data values for the fields, with descriptions.

Standard data values are given for the following tables:

Table A	Admit Type (UB)
Table B	Admit Source (UB)
Table C	Place of Service (CMS 1500)
Table D	Place of Service (from UB Type of Bill)
Table E	Discharge Status (UB Patient Status)
Table F	Type of Service (CMS 1500)
Table G	Servicing Provider Type
Table H	Servicing Provider Specialty (CMS 1500)
Table I	Service Category I-A: MCO I-B: SCO I-C: One Care (ICO)
Table K	Bill Classifications – (UB Bill Classification, 3rd digit)
Table M	Present on Admission (UB)

Note: The abbreviation **NEC** after a description stands for **Not Elsewhere Classified**.

TABLE A
Type of Admission (UB)

Value	Definition
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
6-8	Reserved for National Assignment
9	Information not available

TABLE B
Source of Admission (UB)

Value	Description
1	Physician Referral
2	Clinic/Outpatient Referral
3	HMO Referral
4	Transfer from Hospital
5	Transfer from SNF
6	Transfer from another Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information not available
A	RESERVED FOR ASSIGNMENT BY THE NUBC (END 10/1/07)
B	TRANSFER FROM ANOTHER HOME HEALTH AGENCY
C	RESERVED FOR ASSIGNMENT BY THE NUBC (END 7/1/10)
D	TRANSFER FROM ONE UNIT TO ANOTHER - SAME HOSP
E	TRANSFER FROM AMBULATORY SURGICAL CENTER
F	TRANSFER FROM HOSPICE/ENROLLED IN HOSPICE PROGRAM

For Newborns

Value	Description
1	Normal Delivery
2	Premature Delivery
3	Sick Baby
4	Extramural Birth

TABLE C
Place of Service (HCFA 1500)
last updated November 1, 2009

Value	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (effective 10/1/05)
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison-Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)

Value	Place of Service Name	Place of Service Description
14	Group Home*	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (This code is available for use immediately with a final effective date of May 1, 2010)
18-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

Value	Place of Service Name	Place of Service Description
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)

	Facility	
58-59	Unassigned	N/A

Value	Place of Service Name	Place of Service Description
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

* Revised, effective April 1, 2004.

** Revised, effective October 1, 2005

TABLE D
Place of Service (from UB Bill Type – 1st & 2nd digits)

Type of Facility (1st digit)

Value	Description
1	Hospital
2	Skilled Nursing Facility (SNF)
3	Home Health Agency (HHA)
4	Christian Science (Hospital)
5	Christian Science (Extended Care)
6	Intermediate Care
7	Clinic (refer to *Clinics Only* for 2nd digit)
8	Substance Abuse or Specialty Facility
9	Halfway House

Bill Classifications – Facilities (2nd digit)

Value	Description
1	Inpatient (including Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other
5	Basic Care
6	Complementary Inpatient
7	Complementary Outpatient
8	Swing Beds
9	Halfway House

Bill Classifications – Clinics only (2nd digit)

Value	Description
1	Rural Health Clinic
2	Hospital-based or Freestanding End State Renal Dialysis Facility
3	Freestanding Clinic
4	Other Rehab Facility (ORF) or Community Mental Health Center
5	Comprehensive Outpatient Rehab Facility (CORF)
6-8	Reserved for national assignment
9	Other

TABLE D (cont'd)

Place of Service (from UB Bill Type – 1st & 2nd digits)

Bill Classifications – Specialty Facility (2nd digit)

Value	Description
1	Hospice (non-hospital based)
2	Hospice (hospital based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
5	Critical Access Hospital
6	Residential Facility
7-8	Reserved for national assignment
9	Other

TABLE E
Discharge Status (UB Patient Status)

Value	Description
01	Discharged alive to home / self care (routine discharge)
02	Discharged/Transferred to short term general hospital
03	Discharged/Transferred to skilled nursing facility (SNF)
04	Discharged/Transferred to intermediate care facility (ICF)
05	Discharged/Transferred to other facility
06	Discharged/Transferred to home care
07	Left against medical advice
08	Discharged/Transferred to home under care of a home IV drug therapy provider
09	Admitted as an inpatient to this hospital
10 – 19	Discharged to be defined at State level if necessary
20	Expired (Did not recover – Christian Science Patient)
21 – 29	Expired to be defined at State level if necessary
30	Still a patient
31 – 39	Still a patient to be defined at State level if necessary
40	Expired at home (Hospice claims only)
41	Died in a medical facility (Hospice claims only)
42	Place of death unknown (Hospice claims only)
43 – 99	Reserved for National Assignment

TABLE F
Type of Service (CMS 1500)

Value	Description
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Lab
6	Therapeutic Radiology
7	Anesthesia
8	Surgical Assistant
9	Other Medical Items or Services
0	Blood Charges
A	Used DME
B	High risk screening mammography
C	Low risk screening mammography
D	Ambulance (effective 4/95)
E	Enteral/Parenteral nutrients/supplies
F	ASC Facility
G	Immunosuppressive drugs
H	Hospice Services
I	DME Purchase
J	Diabetic shoes
K	Hearing items & services
L	ESRD supplies
M	Monthly capitation payment for dialysis
N	Kidney Donor
P	Lump sum purchase of DME, prosthetics, orthotics
Q	Vision items or services
R	DME Rental
S	Surgical dressings or other medical supplies
T	Psychological Therapy
U	Occupational Therapy
V	Pneumococcal/Flu/Hepatitis B Vaccine
W	Physical Therapy
Y	Second Surgical Opinion
Z	Third Surgical Opinion

TABLE G
Servicing Provider Type

Value	Description
00	Placeholder PCP
01	Acute Care Hospital-Inpatient
02	Acute Care Hospital-Outpatient
03	Chronic Hospital-Inpatient
04	Chronic Hospital-Outpatient
05	Ambulatory Surgery Centers
06	Trauma Center
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep. (NEC)
21	Mental Health Facilities
22	Chemical Dependency Treatment Ctr.
23	Mental Health/Chem Dep Day Care
25	Rehabilitation Facilities
30	Long-Term Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Cont. Care Retirement Community
37	Day/Night Care Center
38	Hospice
40	Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
50	Physician
51	Medical Doctor MD
52	Osteopath DO
53	Allergy & Immunology
54	Anesthesiology
55	Colon & Rectal Surgery
56	Dermatology
57	Emergency Medicine
58	Family Practice
59	Geriatric Medicine
60	Internist (NEC)
61	Cardiovascular Diseases
62	Critical Care Medicine

TABLE G
Servicing Provider Type (cont'd)

Value	Description
63	Endocrinology/Metabolism
64	Gastroenterology
65	Hematology
66	Infectious Disease
67	Medical Oncology
68	Nephrology
69	Pulmonary Disease
70	Rheumatology
71	Neurological Surgery
72	Nuclear Medicine
73	Obstetrics/Gynecology
74	Ophthalmology
75	Orthopedic Surgery
76	Otolaryngology
77	Pathology
78	Pediatrician (NEC)
79	Pediatric Specialist
80	Physical Medicine and Rehabilitation
81	Plastic Surgery/Maxillofacial Surgery
82	Preventative Medicine
83	Psychiatry/Neurology
84	Radiology
85	Surgeon
86	Surgical Specialist
87	Thoracic Surgery
88	Urology
95	Dentist
96	Dental Specialist
99	Podiatry
100	Unknown Clinic
120	Chiropractor
125	Dental Health Specialists
130	Dietitian
135	Medical Technologists
140	Midwife
145	Nurse Practitioner
146	Nursing Services
150	Optometrist
155	Pharmacist
160	Physician's Assistant

TABLE G
Servicing Provider Type (cont'd)

Value	Description
165	Therapy (physical)
170	Therapists (supportive)
171	Psychologist
175	Therapists (alternative)
180	Acupuncturist
185	Spiritual Healers
190	Health Educator
200	Transportation
205	Health Resort
210	Hearing Labs
215	Home Health Organization
220	Imaging Center
225	Laboratory
230	Pharmacy
235	Supply Center
240	Vision Center
245	Public Health Agency
246	Rehab Hospital-Inpatient
247	Rehab Hospital-Outpatient
248	Psychiatric Hospital-Inpatient
249	Psychiatric Hospital-Outpatient
250	Community Health Center
301	General Hospital
302	Certified Clinical Nurse Specialist
303	Infusion Therapy
304	Palliative Care Medicine
305	Adult Day Health
306	Adult Foster Care / Group Adult Foster Care
307	Fiscal Intermediary Services (FIS)
308	Personal Care Management Agency
309	Independent Living Centers
310	Day Habilitation
311	Durable Medical Equipment
312	Oxygen And Respiratory Therapy Equip
313	Prosthetics
314	Orthotics
315	Renal Dialysis Clinics
316	Respite Care
317	Intensive Residential Treatment Program (IRTP)
318	Complex Care Management
319	Special Programs
320	Recovery Learning Community (RLCs)
321	Certified Peer Specialist
322	Emergency Services Program (ESP)
323	Community Health Worker
324	Hospital Licensed Health Center

TABLE G
Servicing Provider Type (cont'd)

Value	Description
325	Aging Services Access Point (ASAP)
326	Geriatric Mental Health
327	Child Mental Health
328	Deaf and Hard of Hearing Independent Living Services Programs
329	Home Modification Service Providers
330	Transitional Assistance (across settings) Providers
331	Medication Management Providers
332	Substance Abuse Treatment Center
333	Magnetic Resonance Centers
334	Psych Day Treatment
335	QMB (Qualified Medicare Beneficiaries) Only Provider
336	Group Practice Physicians
337	School-Based Clinic or Health Center
338	Billing Agent

TABLE H
Servicing Provider Specialty (from CMS 1500)

Value	Description
01	General Practice
02	General Surgery
03	Allergy / Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative therapy
13	Neurology
14	Neurosurgery
15	Speech Language Pathologists
16	Obstetrics / Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (Dentists Only)
20	Orthopedic Surgery
22	Pathology
23	Sports Medicine
24	Plastic & Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery
29	Pulmonary Disease
30	Diagnostic Radiology
31	Intensive Cardiac Rehabilitation
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery

TABLE H
Servicing Provider Specialty (cont'd)

Value	Description
41	Optometrist
42	Certified Nurse Midwife
43	CRNA, Anesthesia Assistant
44	Infectious Diseases
45	Mammography Screening Center
46	Endocrinology
48	Podiatrist
49	Ambulatory Surgery Center
50	Nurse Practitioner
51	Med Supply Co w/Certified Orthotist
52	Med Supply Co w/Certified Prosthetist
53	Med Supply Co w/Certified Prosthetist/Orthotist
54	Med Supply Co not included in 51, 52 or 53
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Prosthetist/Orthotist
58	Individuals not included in 55, 56 or 57
59	Ambulance Service Supplier
60	Public Health or Welfare Agency (Federal, State & Local Govt)
61	Voluntary Health Agency (ex: Planned Parenthood)
62	Psychologist
63	Portable X-Ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapist
68	Clinical Psychologist
69	Clinical Laboratory
70	Multispecialty Clinic or Group Practice
71	Registered Dietician/Nutrition Professional
72	Pain Management
73	Mass Immunization Roster Biller
74	Radiation Therapy Centers
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine

TABLE H
Servicing Provider Specialty (cont'd)

Value	Description
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers (i.e. Drug, & Department Stores)
88	Unknown Supplier/Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
95	Independent Physiological Lab
96	Optician
97	Physician Assistant
98	Gynecologist/Oncologist
99	Unknown Physician Specialty
A0	Hospital
A1	SNF
A2	Intermediate Care Facility
A3	Nursing Facility, Other
A4	HHA
A5	Pharmacy
A6	Medical Supply Co w/Respiratory Therapist
A7	Department Store
A8	Grocery Store
A9	Dentist
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency
B5	Ocularist

TABLE I – A
Service Category (Using the 4B reporting groups)

Value	Description
1	Capitated Physician Services
2	Fee For Service Physician Services
3	Behavioral Health –Inpatient Services
4	Behavioral Health –Diversionary Services *
5	Behavioral Health –Emergency Services Program (ESP) Services
6	Behavioral Health –Mental Health Outpatient Services *
7	Behavioral Health –Substance Abuse Outpatient Services *
8	Behavioral Health –Other Outpatient Services *
9	Facility- Medical/Surgical
10	Facility- Pediatric/Sick Newborns
11	Facility- Obstetrics
12	Facility- Skilled Nursing Facility/Rehab
13	Facility- Other Inpatient
14	Facility- Emergency Room
15	Facility –Ambulatory Care
16	Prescription Drug
17	Laboratory
18	Radiology
19	Home Health
20	Durable Medical Equipment
21	Emergency Transportation
22	Therapies
23	Other (Please use this for Vision and Dental claims)
24	Other Alternative Care
25	Mental Health and Substance Abuse Outpatient Services (MBHP Only) *
26	Outpatient Day Services (MBHP Only) *
27	Non-ESP Emergency Services (MBHP Only) *
28	Behavioral Health –Diversionary Services – 24-Hour
29	Behavioral Health – Diversionary Services – Non-24-Hour
30	Behavioral Health –Standard Outpatient Services
31	Behavioral Health –Other Services
32	Behavioral Health – Intensive Home or Community Based Outpatient Services for Youth (Please note this new category is where all CBHI services, except youth mobile crisis intervention would be listed. Youth mobile crisis intervention would be considered part of the Emergency Services Program Services.)

*** Use these categories *only* for those claims with Dates of Service before 07/01/2010,**

TABLE I – B
Service Category (Using the SCO reporting groups)

Value	Description
101	Acute Inpatient
102	Chronic Inpatient
103	Outpatient Clinic
104	Mental Health/Substance Abuse
105	Physicians
106	Nonphysician Practitioners
107	Vision Care
108	Dental Care
109	Therapies
110	Pharmacy
111	Laboratory, radiology, testing
112	Institutional Long Term Care
113	Community Long Term Care
114	Waiver Services
115	Transportation
116	Supplies/ Durable Medical Equipment
117	Hospice
118	Care Management
119	Miscellaneous

TABLE I – C
Service Category (Using the One Care - ICO reporting groups)

Value	Description
201	Acute Inpatient
202	Inpatient – MH/SA
203	Hospital Outpatient
204	Outpatient – MH/SA
205	Professional
210	Pharmacy
212	Pong-Term Care (LTC) Facility
213	Homer and Community Based Services (HCBS)/Home Health
215	Transportation
216	Durable Medical Equipment (DME) and Supplies
217	*All Other

*Should follow the definition in the “Quarterly Financial Report” submitted to EOHHS Budget Unit

TABLE K
Bill Classifications - Frequency (3rd digit)

Value	Description
0	Nonpayment/Zero Claims
1	Admit thru discharge claim
2	Interim-first claim
3	Interim –continuing claim
4	Interim-last claim
5	Late charges only claim
6	Adjustment of prior claim
7	Replacement of prior claim
8	Void/back out of prior claim
9	Final claim for Home Health PPS episode
A	Admission/Election Notice
B	Hospice termination revocation notice
C	Hospice change of provider notice
D	Hospice Void/back out
E	Hospice change of ownership
F	Beneficiary Initiated adjustment claim-other
G	CWF Initiated adjustment claim-other
H	CMS Initiated adjustment claim-other
I	Intermediary adjustment claim (other than PRO or Provider)
J	Initiated adjustment claim-other
K	OIG initiated adjustment claim
L	Reserved for national assignment
M	MSP initiated adjustment claim
N	PRO adjustment Claim
O	Nonpayment/Zero Claims
P-W	Reserved for national assignment
X	Void/back out a prior abbreviated encounter submission
Y	Replacement of a prior abbreviated encounter submission
Z	New abbreviated encounter submission

TABLE M
Present on Admission (UB)

Value	Definition
Y	Yes, present at the time of IP admission
N	No, not present at the time of IP admission
U	No information in the record. Documentation is insufficient to determine if condition is POA
W	Clinically undetermined. Provider is unable to clinically determine whether condition was POA or not
Blank	Exempt from POA reporting. Leave blank if condition is on the “not applicable” list ;

8.0 Quantity and Quality Edits, Reasonability and Validity Checks

Raw Data

- Correct layout format
- Fields are correct in size and type of data (alpha vs. numeric)
- Missing fields
- Accurate data type (no unusual characters)
- Reasonability of data
- ***ICD Version Qualifier*** (field # 193) is populated on every encounter claim record that has either ICD diagnosis codes or ICD procedure codes.
- All ICD diagnosis and ICD procedure codes on a claim record are consistent with ICD Version Qualifier.

Data Quality

- Each field is checked for both quantity and quality
- Distribution reports
- Percentage reports
- Valid value reports
- Reasonability reports

#	Field Name	MassHealth Standard
1	Claim Payer	100% present
2	Claim Category	100% present and valid, as found in Data Elements table.
3	Plan Identifier	100% present
4	Record Indicator	100% present
5	Claim Number	100% present
6	Claim Suffix	100% present
7	Header / Detail Claim Line Indicator	100% present
8	Recipient DOB	100% present and valid, as compared to encounter service dates
9	Recipient Gender	100% present and valid, as found in Data Elements table
10	Recipient ZIP Code	100% present
11	Medicare Code	Provide if applicable
12	Other Insurance Code	100% present and valid, as found in Data Elements table
13	Filler	
14	Claim Type	100% present and valid for MBHP only

#	Field Name	MassHealth Standard
15	Admission Date	100% present and valid value on all Inpatient claims, Long Term Care claims and all hospital (institutional) claims with admission.
16	Discharge Date	100% present and valid value on all Hospital discharges and Long Term Care discharges.
17	From Service Date	100% present and valid date on all claims; dates should be evenly distributed across time
18	To Service Date	100% present and valid date on all claims.
19	Primary Diagnosis	100% present and valid ICD codes on Professional, Hospital and Long Term Care I claims.. Required on all Professional and Institutional claims including Long Term Care, Vision, and Transportation claims. On Transportation claims for the services like “a ride to the grocery store”, MCEs should use generic diagnosis codes such as: V46.3 – Wheelchair dependence; V49.9 – Unspecified problem with limbs and other problems; V58.9 – Unspecified aftercare. Should be submitted on Dental claims when available. Not required on Pharmacy claims. E-codes not valid as primary diagnosis. Consistent with ICD Version Qualifier.
20	Secondary Diagnosis	60% present and valid ICD codes on inpatient facility and 20% present and valid on other records, excluding drug and vision. Not routinely coded on Dental records and LTC. Consistent with ICD Version Qualifier.
21	Tertiary Diagnosis	Provide if available. Consistent with ICD Version Qualifier.
22	Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
23	Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
24	Type of Admission	100% present and valid value *(Admit Type, Table A) on all inpatient claims,* Long Term Care claims, and all hospital (institutional) claims with admission.
25	Source of Admission	100% present and valid value (*Admit Source, Table B*) *on all inpatient claims,* Long Term Care claims, and all hospital (institutional) claims with admission.
26	Procedure Code	98% present and valid in general but should be 100% present on all professional claims .Procedure Code Indicator match (i.e., if

		the code is a “CPT or HCPCS Level 1 Code” then the Procedure code indicator should be “2”).
27	Procedure Modifier 1	Provide if available
28	Procedure Modifier 2	Provide if available
29	Procedure Modifier 3	Provide if available
30	Procedure Code Indicator	100% present and valid if Procedure Code field is filled
31	Revenue Code	98% present and valid on Hospital and Long Term Care claims only and should be 100% present on all Inpatient claim detail lines
32	Place of Service	100% present and valid value *on all hospital (institutional), Long Term Care, and professional claims.*
33	Place of Service Type	100% present and valid on all Institutional and Professional claims, Based on Place of Service field
34	Patient Discharge Status	100% present and valid value on all Inpatient claims, Long term Care claims, and all hospital (institutional) claims with admission.
35	Type of Service	100% present and valid value (*Type of Service, Table F) on Professional claims*
36	Quantity	100% present on all claim categories.
37	NDC Number	98% present and valid values, only on Pharmacy claims, reasonability of values (numeric and 11 digits)
38	Metric Quantity	100% present and valid values, only on Pharmacy claims, reasonability of values (total number of units or volume)
39	Days Supply	100% present and valid values, only on all prescription drug Pharmacy claims.
40	Refill Indicator	100% present and valid values, only on all prescription drug Pharmacy claims.
41	Dispense As Written Indicator	100% present and valid values , only on all prescription drug Pharmacy claims.
42	Dental Quadrant	100% present and valid values (1-4), only on dental claims , where applicable
43	Tooth Number	100% present, only on dental claims, where applicable
44	Tooth Surface	100% present, only on dental claims, where applicable
45	Paid Date	100% present and valid date, falls within submitted date range, falls after “Admit, Discharge, To, and From Dates”
46	Service Class	100% present and valid for MBHP only
47	PCP Provider ID	100% present should be an enrolled provider listed in provider enrollment file. Not applicable to MBHP.
48	PCP Provider ID Type	100% present and valid based on PCP Provider ID field. Not applicable to MBHP.

49	IPA/PMG ID	If applicable, should be an enrolled provider listed in provider enrollment file.
50	Servicing Provider ID	100% present and valid on all claims except Pharmacy. Should be an enrolled provider listed in provider enrollment file.

#	Field Name	MassHealth Standard
51	Servicing Provider ID Type	100% present and valid on all claims except Pharmacy, Based on Servicing Provider ID field
52	Referring Provider ID	If applicable, should be an enrolled provider listed in provider enrollment file.
53	Referring Provider ID Type	100% present and valid, only when Referring Provider ID is present
54	Servicing Provider Class	100% present and valid on all records, as found in the Data Elements table.
55	Servicing Provider Type	100% present and valid value (*Servicing Provider Type, Table G*)
56	Servicing Provider Specialty	100% present and valid value (*Servicing Provider Specialty, Table H*)
57	Servicing Provider ZIP Code	100% present and valid
58	Billing Provider ID	100% present and valid on all claims; should be an enrolled provider listed in provider enrollment file.
59	Authorization Type	100% present and valid for MBHP only
60	Billed Charge	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
61	Gross Payment Amount	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts
62	TPL Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
63	Medicare Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
64	Copay/Coinsurance	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
65	Deductible	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
66	Ingredient Cost	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
67	Dispensing Fee	100% present and valid on prescription drug records, financial field with implied 2 decimals, mathematical check with other dollar amounts only on Pharmacy claims
68	Net Payment	100% present financial field with implied 2 decimals, mathematical check with other dollar amounts

#	Field Name	MassHealth Standard
69	Withhold Amount	If applicable, financial field with implied 2 decimals, mathematical check with other dollar amounts
70	Record Type	100% present and valid on all records, as found in the Data Elements table, dollar amount checks
71	Group Number	100% present and valid
72	DRG	100% present and valid value (001 - 495), on Acute Inpatient Hospital claims, when collected by plan.
73	EPSDT Indicator	Not coded at the present time
74	Family Planning Indicator	Not coded at the present time
75	MSS/IS	Not coded at the present time
76	New Member ID (consistent with above data)	100% Present and valid on all claims; not allowed to be missed or invalid.
77	Former Claim Number	100% present and valid, only when Record Type is not O
78	Former Claim Suffix	100% present and valid, only when Record Type is not O
79	Record Creation Date	100% present and valid date
80	Service Category	100% present and valid (*Service Category, Table I*)
81	Prescribing Prov. ID	100% present and valid on Pharmacy claims. Should be an enrolled provider listed in provider enrollment file.
82	Date Script Written	100% present and valid on Pharmacy claims.
83	Compound Indicator	100% present and valid on prescription drug records
84	Rebate Indicator	100% present and valid on prescription drug records
85	Admitting Diagnosis	100% present and valid value on all Inpatient claims, Long Term Care claims, and all hospital (institutional) claim with admission.
86	Allowable Amount	100% present and valid, financial field with implied 2 decimals, mathematical check with other dollar amounts
87	Attending Prov. ID	100% present should be an enrolled provider listed in provider enrollment file. Inpatient Claims only.
88	Non-covered Days	Provide if applicable
89	External Injury Diagnosis 1	Provide if available. Consistent with ICD Version Qualifier.
90	Claim Received Date	100% present and valid date

91	Frequency	100% present and valid on Inpatient claims.

#	Field Name	MassHealth Standard
92	IPA/PMG ID_Type	100% present and valid, when IPA/PMG ID is present
93	Billing Provider ID _Type	100% present, and valid on all claims.
94	Prescribing Prov. ID _Type	100% present and valid on Pharmacy claims.
95	Attending Prov. ID _Type	100% present, and valid
96	Admission Time	100% present and valid value on Hospital and Long Term Care claims
97	Discharge Time	100% present and valid value on Hospital and Long Term Care claims
98	Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
99	Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
100	Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
101	Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
102	Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
103	Surgical Procedure code 1	Provide if available. Consistent with ICD Version Qualifier.
104	Surgical Procedure code 2	Provide if available. Consistent with ICD Version Qualifier.
105	Surgical Procedure code 3	Provide if available. Consistent with ICD Version Qualifier.
106	Surgical Procedure code 4	Provide if available. Consistent with ICD Version Qualifier.
107	Surgical Procedure code 5	Provide if available. Consistent with ICD Version Qualifier.
108	Surgical Procedure code 6	Provide if available. Consistent with ICD Version Qualifier.
109	Surgical Procedure code 7	Provide if available. Consistent with ICD Version Qualifier.
110	Surgical Procedure code 8	Provide if available. Consistent with ICD Version Qualifier.
111	Surgical Procedure code 9	Provide if available. Consistent with ICD Version Qualifier.
112	Employment	Provide if available
113	Auto Accident	Provide if available
114	Other Accident	Provide if available
115	Total Charges	Provide if available
116	Non Covered charges	Provide if available
117	Coinsurance	Provide if available
118	Void Reason Code	Provide if available
119	DRG Description	Provide if applicable
120	DRG Type	Provide if applicable
121	DRG Version	Provide if applicable
122	DRG Severity of Illness Level	Provide if applicable
123	DRG Risk of Mortality Level	Provide if applicable
124	Patient Pay Amount	Provide if applicable
125	Patient Reason for Visit Diagnosis 1	Provide if applicable. Consistent with ICD Version Qualifier.
126	Patient Reason for Visit Diagnosis 2	Provide if applicable. Consistent with ICD Version Qualifier.
127	Patient Reason for Visit Diagnosis 3	Provide if applicable. Consistent with ICD Version Qualifier.
128	Present on Admission (POA) 1	100% present on Hospital and Long Term Care claims
129	Present on Admission (POA) 2	Provide if Diagnosis 2 is available on Hospital and Long Term Care claims
130	Present on Admission (POA) 3	Provide if Diagnosis 3 is available on Hospital and Long Term Care claims

131	Present on Admission (POA) 4	Provide if Diagnosis 4 is available on Hospital and Long Term Care claims

#	Field Name	MassHealth Standard
132	Present on Admission (POA) 5	Provide if Diagnosis 5 is available on Hospital and Long Term Care claims
133	Present on Admission (POA) 6	Provide if Diagnosis 6 is available on Hospital and Long Term Care claims
134	Present on Admission (POA) 7	Provide if Diagnosis 7 is available on Hospital and Long Term Care claims
135	Present on Admission (POA) 8	Provide if Diagnosis 8 is available on Hospital and Long Term Care claims
136	Present on Admission (POA) 9	Provide if Diagnosis 9 is available on Hospital and Long Term Care claims
137	Present on Admission (POA) 10	Provide if Diagnosis 10 is available on Hospital and Long Term Care claims
138	Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
139	Present on Admission (POA) 11	Provide if Diagnosis 11 is available on Hospital and Long Term Care claims
140	Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
141	Present on Admission (POA) 12	Provide if Diagnosis 12 is available on Hospital and Long Term Care claims
142	Diagnosis 13	Provide if available. Consistent with ICD Version Qualifier.
143	Present on Admission (POA) 13	Provide if Diagnosis 13 is available on Hospital and Long Term Care claims
144	Diagnosis 14	Provide if available. Consistent with ICD Version Qualifier.
145	Present on Admission (POA) 14	Provide if Diagnosis 14 is available on Hospital and Long Term Care claims
146	Diagnosis 15	Provide if available. Consistent with ICD Version Qualifier.
147	Present on Admission (POA) 15	Provide if Diagnosis 15 is available on Hospital and Long Term Care claims
148	Diagnosis 16	Provide if available. Consistent with ICD Version Qualifier.
149	Present on Admission (POA) 16	Provide if Diagnosis 16 is available on Hospital and Long Term Care claims
150	Diagnosis 17	Provide if available. Consistent with ICD Version Qualifier.
151	Present on Admission (POA) 17	Provide if Diagnosis 17 is available on Hospital and Long Term Care claims
152	Diagnosis 18	Provide if available. Consistent with ICD Version Qualifier.
153	Present on Admission (POA) 18	Provide if Diagnosis 18 is available on Hospital and Long Term Care claims
154	Diagnosis 19	Provide if available. Consistent with ICD Version Qualifier.
155	Present on Admission (POA) 19	Provide if Diagnosis 19 is available on Hospital and Long Term Care claims
156	Diagnosis 20	Provide if available. Consistent with ICD Version Qualifier.
157	Present on Admission (POA) 20	Provide if Diagnosis 20 is available on Hospital and Long Term Care claims
158	Diagnosis 21	Provide if available. Consistent with ICD Version Qualifier.
159	Present on Admission (POA) 21	Provide if Diagnosis 21 is available on Hospital and Long Term Care claims
160	Diagnosis 22	Provide if available. Consistent with ICD Version Qualifier.
161	Present on Admission (POA) 22	Provide if Diagnosis 22 is available on Hospital and Long Term Care claims
162	Diagnosis 23	Provide if available. Consistent with ICD Version Qualifier.
163	Present on Admission (POA) 23	Provide if Diagnosis 23 is available on Hospital and Long

		Term Care claims
164	Diagnosis 24	Provide if available. Consistent with ICD Version Qualifier.

#	Field Name	MassHealth Standard
165	Present on Admission (POA) 24	Provide if Diagnosis 24 is available on Hospital and Long Term Care claims
166	Diagnosis 25	Provide if available. Consistent with ICD Version Qualifier.
167	Present on Admission (POA) 25	Provide if Diagnosis 25 is available on Hospital and Long Term Care claims
168	Diagnosis 26	Provide if available. Consistent with ICD Version Qualifier.
169	Present on Admission (POA) 26	Provide if Diagnosis 26 is available on Hospital and Long Term Care claims
170	Present on Admission (POA) EI 1	Provide if External Injury Diagnosis 1 is available on Hospital and Long Term Care claims
171	External Injury Diagnosis 2	Provide if available. Consistent with ICD Version Qualifier.
172	Present on Admission (POA) EI 2	Provide if External Injury Diagnosis 2 is available on Hospital and Long Term Care claims
173	External Injury Diagnosis 3	Provide if available. Consistent with ICD Version Qualifier.
174	Present on Admission (POA) EI 3	Provide if External Injury Diagnosis 3 is available on Hospital and Long Term Care claims
175	External Injury Diagnosis 4	Provide if available. Consistent with ICD Version Qualifier.
176	Present on Admission (POA) EI 4	Provide if External Injury Diagnosis 4 is available on Hospital and Long Term Care claims
177	External Injury Diagnosis 5	Provide if available. Consistent with ICD Version Qualifier.
178	Present on Admission (POA) EI 5	Provide if External Injury Diagnosis 5 is available on Hospital and Long Term Care claims
179	External Injury Diagnosis 6	Provide if available. Consistent with ICD Version Qualifier.
180	Present on Admission (POA) EI 6	Provide if External Injury Diagnosis 6 is available on Hospital and Long Term Care claims
181	External Injury Diagnosis 7	Provide if available. Consistent with ICD Version Qualifier.
182	Present on Admission (POA) EI 7	Provide if External Injury Diagnosis 7 is available on Hospital and Long Term Care claims
183	External Injury Diagnosis 8	Provide if available. Consistent with ICD Version Qualifier.
184	Present on Admission (POA) EI 8	Provide if External Injury Diagnosis 8 is available on Hospital and Long Term Care claims
185	External Injury Diagnosis 9	Provide if available. Consistent with ICD Version Qualifier.
186	Present on Admission (POA) EI 9	Provide if External Injury Diagnosis 9 is available on Hospital and Long Term Care claims
187	External Injury Diagnosis 10	Provide if available. Consistent with ICD Version Qualifier.
188	Present on Admission (POA) EI 10	Provide if External Injury Diagnosis 10 is available on Hospital and Long Term Care claims
189	External Injury Diagnosis 11	Provide if available. Consistent with ICD Version Qualifier.
190	Present on Admission (POA) EI 11	Provide if External Injury Diagnosis 11 is available on Hospital and Long Term Care claims
191	External Injury Diagnosis 12	Provide if available. Consistent with ICD Version Qualifier.
192	Present on Admission (POA) EI 12	Provide if External Injury Diagnosis 12 is available on Hospital and Long Term Care claims
193	ICD Version Qualifier	100 % Present on all Professional and Institutional claims. 100% required on all other claims when at least one ICD diagnosis code or ICD surgical procedure code is submitted..
194	Procedure Modifier 4	Provide if available
195	Service Category Type	100% present and valid
196	Ambulance Patient Count	Provide if applicable
197	Obstetric Unit Anesthesia Count	Provide if applicable
198	Prescription Number	100% present on Pharmacy claims

199	Taxonomy Code	Provide if available

#	Field Name	MassHealth Standard
200	Rate Increase Indicator	Provide if applicable
201	Bundle Indicator	100% present on bundled claims
202	Bundle Claim Number	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications
203	Bundle Claim Suffix	Provide if available. Follow instructions in Section 2.0 - Data Element Clarifications

9.0 Appendices

9.1 Appendix A - *Provider Data Set Guidelines*

1. Provider Data submitted is expected to be a snap shot at the time the provider file is created for encounter data submission.
2. **One record** per Provider ID and Provider ID Type is expected to be sent in the provider file included in the encounter submission. However, ***if*** MCEs find it ***necessary*** to include multiple records per provider ID and ID Type and ***only*** because of ***contractual*** changes in between submissions, then the provider effective and term dates have to be populated correctly to reflect the actual dates of these changes. In this case, the effective and term dates per Provider ID and Provider ID Type must not overlap.
3. Providers with multiple servicing sites or addresses ***must*** have different IDs for each site location.
4. Effective and Term dates should ***not*** be blank. Providers who are enrolled with the MCE at the time of a data submission are expected to have "End of time" Term date in that submission. The preferred value for the "End of Time" field is '99991231'.

Provider Error Process:

There is no manual override for the provider file and the error process is as follows:

1. Provider records with null ID and/or null ID Type will not be loaded into our system and will be rejected and returned in the provider error response file.

2. No duplicate Provider records should be submitted in the encounter provider data file. However, if duplicate records per provider ID, Provider ID Type and Provider Term Date are ***erroneously*** submitted, one record will be accepted based on "best fit" logic and all other records will be rejected and returned in the provider error response file

3. "Best" fit logic picks one record per provider ID, provider ID Type and provider Term Date in a provider file, based on the record that has the most populated information (NPI, provider name, address, tax ID, license number, and Medicaid Number, respectively).

4. If MCEs send records with "null" or missing effective/term dates, a non-fatal error will be generated. These records will load into our system in order to ensure that claims do not get rejected. However, these records will also be returned in the provider error response file. MCE's will be expected to correct and resubmit these records in the Correction file for "Production" data submissions.

5. If provider records have all attributes missing except for provider ID and ID Type then these records will load into our system in order to ensure that claims do not get rejected. However, a non-fatal error will be generated and the error records will be returned in the provider error response file. MCE's will be expected to correct and resubmit these records in the Correction file for "Production" data submission.

6. Provider records rejected for the above reasons would be returned to the MCEs in the Provider Error Response file with the following error description:

    a. “Provider ID is Missing”
    b. “Provider ID Type is Missing”
    c. “Duplicate Records”
    d. “Provider Effective or Term Dates are missing”
    e. “All Other Provider Attributes are Missing”

    If the provider data file does not have any errors, a zero-byte provider error response file will be generated.

7. A provider “correction file” for provider records rejected for one of the above reasons, should be submitted with the zipped “Correction file” for the ***same*** submission. It should ***only include*** provider records from the provider error response file generated for that same submission.

    Any claims that are sent in a manual override and are forced into our system, and refer to a rejected provider record that did not get corrected, would be referring to a provider that does not exist in our system in the case when the provider IDs are missing, a provider that has missing attributes, or is the “single” provider record that got into our system in the case of duplicate records.

8. A provider file with 20% or more missing NPIs will get rejected and must be resubmitted in order to process the encounter data submission. At least 80% of the records should have NPI.

Appendix B - *Major Revisions*

Data Requirements:

1. Defined Paid Claim (Page 6)
2. Clarified that MCEs must submit paid claim lines (Page 7)
3. Added a request for monthly financial reports (Page 7)

How to Use this Document

4. Clarified that MCEs must use Encounter Record Layout section for data file layout and that all instructions in this document should be carefully followed (Page 7)

Data Elements Clarifications:

5. Added a clarification that MassHealth member IDs submitted in the Encounter data must be active as of the date of submission (Page 9)
6. Added a clarification on the requirement to report Provider NPI (Page 9)
7. Added a clarification on Dollar Amounts (Record Indicator) (Pages 10 -12)
8. Added a clarification on how MassHealth defines Inpatient Claims in the Encounter Data (Page 12)
9. Added a clarification on Administrative Fees (Page 13)
10. Added a clarification for two new fields – Bundle Claim Number and Bundle Claim Suffix (Page 13 - 14)

Encounter Data Set Elements:

11. Added fields (Pages 28 – 34)
12. Added "Rate Increase Indicator" to identify ***services*** that are eligible for ACA – 1202 rate increase.(Page 33)
13. Added a clarification to field "Primary Care Eligibility Indicator" in **Provider Data Set** (Page 37)
14. Added a new table under section 3.2 for MCE Internal Provider Type Data Set Elements) to get the Provider Types that are internally used by MCEs (Page 38)

Encounter Record Layout:

15. Clarified format (Pages 42 – 49)
16. Added a layout for new table to get the Provider Types that are internally used by the MCEs (MCE Internal Provider Type Layout - Page 48)

Media Requirements:

17. Modified data submission requirement from fixed-length data files to pipe-delimited files (Page 56)
18. Added the SCOs to data submission specifications (Pages 56 - 57)
19. Added One Care (ICOs) to 6.0 Media Requirements (Page 59) – 10/30/2014,
20. Added Instruction on Monthly Financial Report (Page 58)
21. Changed Instructions on Monthly Financial Report (Pages 62 - 63) - 10/30/2014

Standard Data Values:

22. Updated values in Table C (Pages 70-73)
23. Updated values in Table G (Pages 78-81)
24. Added Table I-B Service Category - SCO (Page 86)
25. Added Table I-C Service Category – One Care-ICO (Page 92) – 10/30/2014
26. Added Table M Present on Admission (Page 89)

9.2 Appendix C – *Member Enrollment File Specifications*

1. Overview:

MassHealth is requesting that MCEs begin submitting member enrollment data on a monthly basis as part of the Encounter data submission. MassHealth is requesting member level enrollment data to facilitate the implementation of multiple projects like the Primary Care Payment Reform Initiative and Integrated Health Care.

In particular, the updated Member Enrollment File is meant to capture member enrollment with a PCP and member demographics. In addition, MassHealth would like to start documenting information on Care Coordination and/or Care Management providers as a means to better understand this aspect of care delivery.

2. Technical Specifications:

MCE will submit a full refresh of the following three files on a monthly basis for the first six months. During this six month period MassHealth will evaluate the data and work with the MCE to determine the best approach for migrating to an incremental data approach rather than a full refresh.

Member File

1. Each MCE will submit an initial history file of all MassHealth and CommCare members who were enrolled with the MCE on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. The Member File will have the **member** MassHealth ID and demographic information.
3. The Member File will be a snapshot as of the end of the month prior to the submission date. For example, the "as of" date for data submitted end of September 2013 is August 31, 2013.
4. The Member File will only have the most current member demographic information.
5. MCE will submit a full refresh of the Member File on a monthly basis.
6. Member records submitted by MCEs will stay in our system unless the MCE sends us a "delete" file with the member records that need to be deleted from our system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.*** In this case, the member in the delete file will be deleted from both the Member File and the Member Enrollment File (see section 3 –Submission Process).

Member Enrollment File

1. MCE will submit an initial history file of all MassHealth and CommCare (CarePlus starting 1/1/2014) members who were enrolled with a **PCP and/or CM Provider** (Care Coordinator, Care Coordination Program, Care Manager, or Care Management Program) on or after 1/1/2010 including members who ended their enrollment after 1/1/2010.
2. Members who are enrolled with an MCE and are in the Member File, but do not have PCP or CM Provider enrollment will ***not*** be included in this file.
3. All members included in the Member Enrollment File should also be included in the Member File.
4. The file will include ***all*** enrollments since 1/1/2010. For example, if a member had three PCP enrollments during this period then all three enrollments will be reported in the file.
5. Begin and End Enrollment dates must reflect changes in member ***enrollment*** with a PCP, CM Provider and changes in Practice affiliation.
6. Any member enrollment record that existed in prior files and is not submitted in current files would be "soft" deleted from MassHealth system.

A. Member Enrollment File Providers and Practices

1. Care Coordinators, Care Managers, Care Coordination and Management Programs are all referred to as **CM Providers**.
2. PCPs and CM Providers are all considered **"Providers**" and their IDs will be submitted in the Provider ID field.
3. The Practice that the above providers are associated with is referred to as "**Practice**" and the Practice Provider ID will be submitted in the Practice ID field.
4. If one Practice location cannot be identified for the member enrollment with a PCP then MCEs should provide the ID for the PCP's head contracting entity in the Practice ID field.
5. A "Provider Enroll Type" field indicates whether the Provider ID is for a PCP or a CM Provider.
6. A "Care Level" field indicates whether the **CM Provider IDs** are submitted **at the MCE or Practice/Provider level**.
7. If a member is enrolled with two types of providers (e.g. PCP and Care Manager), two records will be submitted with two different Provider Enroll Types for that member even if the PCP happens to be the same provider as the Care Manager.

8. MCEs would need to submit unique identifiers for the **CM Providers**. These unique identifiers must be maintained by the MCE and must be included in the **Care Management Provider File** (see below)
9. The only information required in the Member Enrollment File for a Provider and Practice is Provider ID/Provider ID Type and Practice ID/Practice ID Type.
10. Every Provider ID **for a PCP** and every Practice ID must exist in the Provider File submitted in the Encounter file.
11. Every Provider ID **for a CM Provider** must exist in the **Care Management Provider File** (see Care Management Provider File below)
12. Any change in ***Provider or Practice*** demographic information would ***not*** require the submission of any new records in the Member Enrollment File. Demographic information will be maintained in the Encounter Provider File or the Care Management Provider File.

B. Member Enrollment File Begin and End Enrollment Dates

1. The Member Enrollment File will have "Begin" and "End" Enrollment Dates to identify all enrollments with a PCP or CM Providers.
2. Any change in the member enrollment with a provider would require additional records with new "Begin" and "End" Enrollment dates.
3. "Begin" and "End" enrollment dates must be submitted with each record. End Enrollment Date for "active" enrollments with a provider will be submitted as "End of Time" (EOT – 99991231)

Care Management Provider File

1. MCE will submit a Care Management Provider File that includes all **CM Providers** (Care Coordinators, Care Managers, Care Coordination and Management Programs) ***who are not inlcuded in the Encounter Provider File.***
2. The Care Management Provider File will have "Effective" and "Term" dates for CM Providers that must be submitted with each record. Term Date for "active" records should be submitted as "End of Time" (EOT – 99991231)

3. <u>Submission Process</u>:

1. Member ZIP File must be named "MCE_MEMBER_YYYYMMDD.zip" (e.g. BMC_MEMBER_20130831.zip).
2. Member ZIP File must include Member File, Member Enrollment File, Care Management Provider File and Member Metadata File.

3. Member File, Member Enrollment File, and Care Management Provider File must be submitted as “Pipe” delimited text files.
4. The member metadata file in the Member ZIP File must be named MEM_metadata.txt.
5. Member ZIP File must be submitted at the same time the Encounter data is submitted.
6. Moving forward, the **Encounter** Zip File is required to be named **MCE_Claims_YYYYMMDD.zip** (e.g. BMC_Claims_20130930.zip). This the only change required in the current Encounter data submission process. Please use this naming convention for the encounter data file even when the member file is not sent. The Manual Override file should be named **MCE_Claims_YYYYMMDD**_MO**.zip**.
7. After the data transfer is complete, include a zero byte file called **mce_done.txt** for the Encounter Zip file and **mem_mce_done.txt** for the Member Zip file. The file “mem_mce_done.txt” is only needed when the Member Zip file is submitted.

Member Metadata File

Metadata Field	**Submission**
MCE_Id="Value"	Mandatory
Date_Created=" YYYYMMDD"	Mandatory
Member_File_Name="Value"	Mandatory
MemEnroll_File_Name="Value"	Mandatory
CareMgmt_File_Name="Value"	Mandatory
Total_Member_Records="Value"	Mandatory
Total_MemEnroll_Records="Value"	Mandatory
Total_CareMgmt_Records="Value"	Mandatory
Time_MemEnroll_From="Value" (YYYYMMDD)	Mandatory
Return_To=”Email Address”	Mandatory

Notes:

i. Total_Member_Records is the total number of records in the Member File
ii. Total_MemEnroll_Records is the total number of records in the Member Enrollment File.
iii. Time_MemEnroll_From is the earliest “Begin” Enrollment Date in the Member Enrollment File.
iv. Total_CareMgmt_Records is the total number of records in the Care Management Provider File.
v. For files missing from a submission set corresponding field value to “none.txt”

Test Member Zip File

1. Test Member ZIP File must be dropped in FTP server in "test_mco" folder.
2. If the Provider IDs in the Member Enrollment File have not been sent to MassHealth in prior submissions, a Test Provider File needs to be dropped in the "test_mco" folder along with the Member Zip File.
3. Test Provider File must be named MCE_TestProvider_YYYYMMDD.txt (e.g. BMC_ TestProvider_20130930.txt) and must be submitted outside the Test Member Zip File.
4. All IDs for PCPs and Practices in the Test Member Enrollment File should exist in Encounter Provider File from prior submissions or in Test Provider File.
5. All IDs for **CM Providers** in the Test Member Enrollment File should exist in the Test Care Management Provider File.
   If Care Management Provider File cannot be submitted set corresponding field value in Member Metadata File to "none.txt".
6. All member IDs in Member Enrollment File should exist in Member File

Production Member Zip File

1. Production Member ZIP File must be dropped in FTP server in "ehs_dw" folder.
2. There is no change in the Encounter data submission process.
   Encounter data zip file must be named MCE_Claims_YYYYMMDD.zip (e.g. BMC_Claims_20130930.zip)
3. Both Member ZIP File and Encounter Data ZIP File should be submitted at the same time.
4. All IDs for PCPs and Practices in the Production Member Enrollment File should exist in the **Encounter Provider File**.
5. All IDs for **CM Providers** in the Production Member Enrollment File should exist in the Production Care Management Provider File.
   If Care Management Provider File cannot be submitted, set corresponding field value in member metadata file to "none.txt"
6. All member IDs in Member Enrollment File should exist in Member File

Member Delete File

1. Member Delete File has the same format as Member File but will only have the member records that need to be deleted from our system. ***This file will only be sent when the MCE determines that the member should never have been part of EOHHS population and had been erroneously sent to MassHealth.***

2. The member in the delete file will be deleted from both the Member File and the Member Enrollment File.
3. Member Delete File will be submitted independently from the Member Zip file and will be named **MCE_DELETE_MEM_YYYYMMDD.txt** (e.g. BMC_DELETE_MEM_20130930.txt).
4. The Member Delete File can be submitted any time, however the MCE must send an email to MassHealth Data Warehouse to notify them about the submission of a delete file.

4. Validation Rules:

Member File

1. All Member IDs submitted in the Member File should exist in MMIS.
2. In the following scenarios, all records for that Member ID will be rejected:
    1. Member ID is missing
    2. Member ID is invalid
    3. Claim Payer (MCE) is missing
    4. Claim Payer (MCE) is not meeting Masshealth Standards

3. The Member File will ***not*** be used as part of the claims validation process. Rejected records in the Member File will ***not*** result in rejecting records from Encounter Claims Data.

Member Enrollment File

1. All Member IDs submitted in the Member Enrollment File must exist in MMIS
2. All Member IDs submitted in the Member Enrollment File must exist in Member File
3. In the following scenarios, all records for that Member ID will be rejected:
    1. Member ID is missing
    2. Member ID is invalid
    3. Provider ID is missing
    4. Provider ID is not found in MCE Provider Files
    5. Provider ID Type is missing
    6. Provider ID Type is not found in MCE Provider Files
    7. Practice ID Type is missing when Practice ID is not missing
    8. Practice ID Type not found in MCE Provider Files when Practice ID is not missing
    9. Provider Enroll Type is missing
    10. Provider Enroll Type is not valid as per specification
    11. Care Level is missing
    12. Care Level is not valid as per specification
    13. Begin Enrollment Date is missing or invalid
    14. End Enrollment Date is missing or invalid
    15. Claim Payer (MCE) is missing

16. Claim Payer (MCE) is not meeting Masshealth Standards

4. The Member Enrollment File will not be used as part of the claims validation process. Rejected records in the Member Enrollment File will not result in rejecting records from Encounter Claims Data

Care Management Provider File

1. All records in the Care Management Provider File will be rejected in the following scenarios:
    - **a.** Claim Payer (MCE) is missing
    - **b.** Claim Payer (MCE) is not meeting Masshealth Standards
    - **c.** CM Provider ID is missing

5. Member Error File:

1. All records in the Member File, Member Enrollment File and Care Management Provider File not meeting validation rules described in Section 4 will be rejected.
2. An error file for the Member File will be posted on the FTP server and will be named "ERR_MCE_MEMBER_YYYYMMDD.txt". (e.g. ERR_BMC_MEMBER_20130930.txt)
3. An error file for the Member Enrollment File will be posted on the FTP server and will be named "ERR_MCE_MEMENROLL_YYYYMMDD.txt". (e.g. ERR_BMC_MEMENROLL_20130930.txt)
4. An error file for Care Management Provider File will be posted on the FTP server and will be named "ERR_MCE_CAREMGMT_YYYYMMDD.txt". (e.g. ERR_BMC_CAREMGMT_20130930.txt)
5. Records that get rejected must be corrected and sent back to Masshealth to get into the system.
6. Member and Member Enrollment correction files should follow the same format as the original files
7. Member and Member Enrollment correction files must be submitted with the Encounter correction/manual override file or must be corrected in the following month's member files submission.
8. Corrected records in Member File, Member Enrollment File or Care Management Provider File that still have errors will never go into MassHealth system and will not be overridden even when submitted along with the Manual Override Encounter file.

6. *File Layout:*

Member File Layout

#	Field	Description	Length	Type	Required	Comments
1	Claim Payer	This code identifies your Managed Care Entity (MCE): 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England xxxx MassHealth PCC Plan This code identifies your Senior Care Organization (SCO): 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan This code identifies your One Care Organization (ICO): 601 Commonwealth Care Alliance 602 Network He 603 Fallon Total Care	9	C	Required	
2	Member ID	The MassHealth ID for the **member**	12	C	Required	
3	Active Status Indicator	Y/N indicates whether the member has a current “Active” enrollment status with the MCE	1	C	Required	
4	Member Birth Date	Member Date of Birth	8	Date YYYYMMDD	Required	
5	Member Death Date	Member Date of Death	8	Date YYYYMMDD	Required	
6	Member First Name	Member first name	100	C	Required	
7	Member Last Name	Member last name	100	C	Required	
8	Member Middle Initial	Member Middle Initial	1	C	Required	

#	Field	Description	Length	Type	Required	Comments
9	Member Gender	The gender of the member: "Male" or "Female". These values should be spelled out and should not be abbreviated	8	C	Required	
10	Member Ethnicity	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
11	Member Race	Please follow the US Office of Management and Budget (OMB) standards for Classification of Race and Ethnicity	75	C	Provide if available	Values should have descriptions and not codes
12	Member Primary Language	The Primary Language of the Member	75	C	Provide if available	Values should have descriptions and not codes
13	Member Address 1	Member Street Address 1	100	C	Required	
14	Member Address 2	Member Street Address 2	100	C	Provider if applicable	
15	Member City	Member City	40	C	Required	
16	Member State	Member State	2	C	Required	
17	Member Zip Code	Member Zip Code	5	C	Required	
18	Homeless Indicator	Y/N. Indicates if the member is homeless	1	C	Provide if available	
19	Communication Access Needs Indicator	Y/N. Indicates if the member has special needs for communicator	1	C	Provide if available	
20	Disability Indicator	Y/N. Indicates if the member has a disability	1	C	Provide if available	
21	Disability Type	Identifies the disability type for a member. This is a place holder until the disability types are clearly defined. Values TBD	30	C	Provide if available	

Member Enrollment File Layout

#	Field	Description	Length	Type	Required	Comments
1	Claim Payer	This code identifies your Managed Care Entity (MCE): 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England xxxx MassHealth PCC Plan This code identifies your Senior Care Organization (SCO): 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan This code identifies your One Care Organization (ICO): 601 Commonwealth Care Alliance 602 Network He 603 Fallon Total Care	9	C	Required	
2	Member ID	The MassHealth ID for the **member**	12	C	Required	

#	Field	Description	Length	Type	Required	Comments
3	Provider Enroll Type	This field indicates the Type of Provider a member is enrolled with. It should reflect the information entered in the Provider ID and ID Type. For example, if Provider Enroll Type is entered as '02' then the Provider ID and ID Type should be for the "Geriatric Coordinator" the member is enrolled with. **The values are as follows:** **01 = PCP** **02 = Geriatric Coordinator** **03 = LTSS Coordinator** **04 = Care Coordinator** **05 = Care Coordination Program (if no assigned care coordinator but member is enrolled in a care coordination program)** **06 = Care Manager** **07 = Care Management Program (if no assigned care manager but member is enrolled in a care management program)**	2	C	Required	This is a key field and it indicates whether the provider fields are for a PCP or CM providers.
4	Provider Enroll Type Description	The Description of the Provider Enroll Type. The description should be consistent with the value selected in Provider Enroll Type. If the value entered in Provider Enroll Type is **"01"** the description should be "PCP" If the value entered in Provider Enroll Type is **"02"** the description should be " Geriatric Coordinator" and so on	40	C	Required	
5	Care Level	This field is required with all CM Providers to indicate whether the Provider ID submitted is at the MCE or Practice/Provider level. If the Provider is a PCP, value "NA" **must** be entered in this field. Values are: "MCE" "PRV" "NA" for "Not Applicable"	3	C	Required	

#	Field	Description	Length	Type	Required	Comments
6	Begin Enrollment Date	This is the beginning enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	
7	End Enrollment Date	This is the end enrollment date with a PCP or CM Providers	8	Date YYYYMMDD	Required	This value should be "99991231" for "active" enrollment which represents End of Time (EOT).
8	Provider ID	Provider ID.	15	C	Required	This ID should be consistent with the ID submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the “Provider Enroll Type” field above. For example, if the Provider Enroll Type was submitted on a record as “01” then the Provider ID for that record would be for a PCP. This applies to all other values in the Provider Enroll Type.

#	Field	Description	Length	Type	Required	Comments
9	Provider ID Type	Provider ID Type is required when the provider is part of prior and current provider files submitted in the encounter data. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Required	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a provider. Information provided in this field should be consistent with the information submitted in the "Provider Enroll Type" field above. For example, if the Provider Enroll Type was submitted on a record as "01" then the Provider ID Type for that record would be the ID Type associated with a PCP. This applies to all other values in the Provider Enroll Type.
10	Practice ID	Practice ID	15	C	Highly important so please provide if available	This ID should be consistent with the ID submitted in the Encounter Provider File for a Practice
11	Practice ID Type	Practice ID Type. The values are: 1 for NPI 6 for MCE Internal ID	1	C	Highly important so please provide if available	This ID Type should be consistent with the ID Type submitted in the Encounter Provider File for a Practice

Care Management Provider File Layout

#	Field	Description	Length	Type	Required	Comments
1	Claim Payer	This code identifies your Managed Care Entity (MCE): 465 Fallon Community Health Plan 469 Neighborhood Health Plan 997 Boston Medical Center HealthNet Plan 998 Network Health 999 Massachusetts Behavioral Health Partnership 470 CeltiCare 471 Health New England xxxx MassHealth PCC Plan This code identifies your Senior Care Organization (SCO): 501 Commonwealth Care Alliance 502 UnitedHealthCare 503 NaviCare 504 Senior Whole Health 505 Tufts Health Plan 506 BMC HealthNet Plan This code identifies your One Care Organization (ICO): 601 Commonwealth Care Alliance 602 Network He 603 Fallon Total Care	9	C	Required	
2	CM Provider ID	The MCE unique identifier for **CM Provider**	15	C	Required	
3	CM Provider Last Name	**CM Provider** last name	100	C	Required	
4	CM Provider First Name	**CM Provider** first name	100	C	Provide if Applicable	
5	CM Provider Gender	M' for Male and 'F' for Female	1	C	Optional	
6	CM Provider Address	**CM Provider** Street Address	120	C	Required	
7	CM Provider City	**CM Provider** City	40	C	Required	
8	CM Provider State	**CM Provider** State	2	C	Required	
9	CM Provider Zip Code	**CM Provider** Zip Code	9	C	Required	

#	Field	Description	Length	Type	Required	Comments
10	CM Provider Phone	**CM Provider** Telephone number	13	C “999999999”	Required	Do not include characters like dashes or brackets – e.g. 6178889900
11	CM Provider Effective Date	Begin effective date for the **CM Provider**	8	C – YYYYMMDD	Required	
12	CM Provider Term Date	End effective date for **CM Provider**	8	C – YYYYMMDD	Required	This value should be "99991231" for "active" CM Provider IDs which represents End of Time (EOT).

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

CONTRACTOR'S REGION (as indicated by an "X")	REGION 1-NORTHERN	City, Town
X		Acton
		Amesbury
		Andover
		Bedford
		Beverly
		Billerica
		Boxford
		Burlington
		Byfield
		Carlisle
		Chelmsford
		Concord
		Danvers
		Dracut
		Dunstable
		Essex
		Everett
		Georgetown
		Gloucester
		Groveland
		Hamilton
		Hathorne
		Haverhill
		Ipswich
		Lawrence
		Lexington
		Lincoln
		Littleton
		Lowell
		Lynn
		Lynnfield
		Malden
		Manchester By The Sea
		Marblehead
		Medford
		Melrose
		Merrimac
		Methuen
		Middleton
		Nahant
		Newbury
		Newburyport
		North Andover
		North Billerica
		North Chelmsford
		North Reading

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

		Nutting Lake
		Peabody
		Pinehurst
		Prides Crossing
		Reading
		Rockport
		Rowley
		Salem
		Salisbury
		Saugus
		South Hamilton
		Stoneham
		Swampscott
		Tewksbury
		Topsfield
		Tyngsboro
		Vill. of Nagog Woods
		Wakefield
		Wenham
		West Boxford
		West Medford
		West Newbury
		Westford
		Wilmington
		Winchester
		Woburn
CONTRACTOR'S REGION (as indicated by an "X")	**REGION 2- GREATER BOSTON**	**City, Town**
X		Accord
		Allston
		Arlington
		Arlington Heights
		Babson Park
		Boston
		Braintree
		Brighton
		Brookline
		Brookline Village
		Cambridge
		Charlestown
		Chelsea
		Chestnut Hill
		Cohasset
		Dedham
		Dorchester
		East Boston
		Greenbush
		Hingham
		Hull
		Hyde Park

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

		Jamaica Plain
		Mattapan
		Milton
		Milton Village
		Minot
		North Scituate
		Norwell
		Norwood
		Quincy
		Randolph
		Readville
		Revere
		Roslindale
		Roxbury
		Scituate
		Somerville
		Waban
		Waverley
		West Roxbury
		Westwood
		Weymouth
		Winthrop
CONTRACTOR'S REGION (as indicated by an "X")	**REGION 3- SOUTHERN**	**City, Town**
X		Abington
		Acushnet
		Assonet
		Attleboro
		Avon
		Barnstable
		Berkley
		Bourne
		Brant Rock
		Brewster
		Bridgewater
		Brockton
		Bryantville
		Buzzards Bay
		Canton
		Carver
		Cataumet
		Centerville
		Chartley
		Chatham
		Chilmark
		Cotuit
		Cummaquid
		Cuttyhunk
		Dartmouth
		Dennis

Dennis Port
Dighton
Duxbury
East Bridgewater
East Dennis
East Falmouth
East Freetown
East Mansfield
East Orleans
East Sandwich
East Wareham
Eastham
Easton
Edgartown
Elmwood
Fairhaven
Fall River
Falmouth
Forestdale
Foxboro
Freetown
Gay Head
Gosnold
Green Harbor
Halifax
Hanover
Hanson
Harwich
Harwich Port
Holbrook
Humarock
Hyannis
Hyannis Port
Kingston
Lakeville
Manomet
Mansfield
Marion
Marshfield
Marshfield Hills
Marstons Mills
Mashpee
Mattapoisett
Menemsha
Middleboro
Middleborough
Monponsett
Monument Beach
Nantucket
New Bedford
North Attleboro
North Carver

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

North Chatham
North Dartmouth
North Dighton
North Eastham
North Easton
North Falmouth
North Marshfield
North Pembroke
North Truro
Norton
Oak Bluffs
Onset
Orleans
Osterville
Pembroke
Plainville
Plymouth
Plympton
Pocasset
Provincetown
Raynham
Raynham Center
Rehoboth
Rochester
Rockland
Sagamore
Sagamore Beach
Sandwich
Seekonk
Sharon
Sheldonville
Siasconset
Somerset
South Carver
South Chatham
South Dartmouth
South Dennis
South Easton
South Harwich
South Orleans
South Wellfleet
South Yarmouth
Stoughton
Swansea
Taunton
Tisbury
Truro
Vineyard Haven
Wareham
Wellfleet
West Barnstable
West Bridgewater

		West Chatham
		West Dennis
		West Falmouth
		West Harwich
		West Hyannisport
		West Tisbury
		West Wareham
		West Yarmouth
		Westport
		Westport Point
		White Horse Beach
		Whitman
		Woods Hole
		Wrentham
		Yarmouth
		Yarmouth Port
CONTRACTOR'S REGION (as indicated by an "X")	**REGION 4- CENTRAL**	**City, Town**
X		Ashburnham
		Ashby
		Ashland
		Athol
		Auburn
		Auburndale
		Ayer
		Baldwinville
		Barre
		Bellingham
		Belmont
		Berlin
		Blackstone
		Bolton
		Boxboro
		Boylston
		Brimfield
		Brookfield
		Charlton
		Charlton City
		Charlton Depot
		Clinton
		Douglas
		Dover
		Dudley
		East Brookfield
		East Douglas
		East Princeton
		East Templeton
		East Walpole
		Fiskdale
		Fitchburg

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

Framingham
Franklin
Ft Devens
Gardner
Gilbertville
Grafton
Groton
Hardwick
Harvard
Holden
Holland
Holliston
Hopedale
Hopkinton
Hubbardston
Hudson
Jefferson
Lancaster
Leicester
Leominster
Linwood
Lunenburg
Manchaug
Marlborough
Maynard
Medfield
Medway
Mendon
Milford
Millbury
Millis
Millville
Natick
Needham
New Braintree
New Salem
Newton
Norfolk
North Brookfield
North Grafton
North Oxford
North Uxbridge
Northborough
Northbridge
Oakdale
Oakham
Orange
Oxford
Paxton
Pepperell
Petersham
Phillipston

		Princeton
		Rochdale
		Royalston
		Rutland
		Sherborn
		Shirley
		Shrewsbury
		South Barre
		South Grafton
		South Lancaster
		South Walpole
		Southborough
		Southbridge
		Spencer
		Sterling
		Still River
		Stow
		Sturbridge
		Subtotal
		Subtotal
		Sudbury
		Sutton
		Templeton
		Townsend
		Upton
		Uxbridge
		Wales
		Walpole
		Waltham
		Warren
		Warwick
		Watertown
		Wayland
		Webster
		Wellesley
		West Boylston
		West Brookfield
		West Groton
		West Upton
		West Warren
		Westborough
		Westminster
		Weston
		Wheelwright
		Whitinsville
		Wilkinsonville
		Winchendon
		Winchendon Springs
		Woodville
		Worcester

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

CONTRACTOR'S REGION (as indicated by an "X")	REGION 5- WESTERN	City, Town
X		Adams
		Agawam
		Alford
		Amherst
		Ashfield
		Ashley Falls
		Becket
		Belchertown
		Berkshire
		Bernardston
		Blanford
		Bondsville
		Buckland
		Charlemont
		Cheshire
		Chester
		Chesterfield
		Chicopee
		Clarksburg
		Colrain
		Conway
		Cummington
		Dalton
		Deerfield
		Drury
		East Longmeadow
		East Otis
		Easthampton
		Egremont
		Erving
		Feeding Hills
		Florida
		Gill
		Glendale
		Goshen
		Granby
		Granville
		Great Barrington
		Greenfield
		Hadley
		Hampden
		Hancock
		Hatfield
		Hawley
		Haydenville
		Heath
		Hinsdale
		Holyoke
		Housatonic

		Huntington
		Lake Pleasant
		Lanesboro
		Lee
		Leeds
		Lenox
		Lenox Dale
		Leverett
		Leyden
		Longmeadow
		Ludlow
		Middlefield
		Mill River
		Monroe
		Monroe Bridge
		Monson
		Montague
		Monterey
		Montgomery
		Mount Hermon
		Mount Washington
		New Ashford
		New Marlborough
		North Adams
		North Amherst
		North Egremont
		North Hatfield
		Northampton
		Northfield
		Otis
		Palmer
		Pelham
		Peru
		Pittsfield
		Plainfield
		Richmond
		Rowe
		Russell
		Sandisfield
		Savoy
		Shattuckville
		Sheffield
		Shelburne
		Shelburne Falls
		Shutesbury
		South Deerfield
		South Egremont
		South Hadley
		South Lee
		Southampton
		Southfield
		Southwick

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

		Springfield
		Stockbridge
		Sunderland
		Thorndike
		Three Rivers
		Tolland
		Turners Falls
		Tyringham
		Ware
		Washington
		Wendell
		Wendell Depot
		West Chesterfield
		West Hatfield
		West Springfield
		West Stockbridge
		Westfield
		Westhampton
		Whately
		Wilbraham
		Williamsburg
		Williamstown
		Windsor
		Woronoco
		Worthington

BOSTON MEDICAL CENTER HEALTH PLAN, INC. APPENDIX F: REGIONS

Appendix G:
Behavioral Health

Exhibit 1: MassHealth Emergency Services Programs (ESPs) Provider List
As of 1/23/2017

BOSTON		
Area: Boston	**24 hour access number: (800) 981-4357** Centralized fax number: (617) 414-8306	
ESP Provider: Boston Medical Center / Boston Emergency Services Team (B.E.S.T.)		
ESP Director: Tasha Ferguson (617) 414-8379 Tasha.Ferguson@bmc.org **Mobile Crisis Intervention Manager**: TBD		
Service Locations	Operating Hours	Cities/Towns in Area
BEST Community Based Location 85 E. Newton Street Boston, MA 02118 (800) 981-4357 (617) 414-8336 Fax (617) 414-8333	**7am-11pm weekdays** **9am-5pm weekends**	Boston (Allston, Dorchester, South Boston, Roxbury, West Roxbury, Jamaica Plain, Mattapan, Roslindale, Hyde Park, Lower Mills), Brighton, Brookline, Charlestown, Chelsea, East Boston, Revere, Winthrop
BEST Community Based Location 25 Staniford Street Boston, MA 02114 (800) 981-4357 (617) 523-1529 Fax (617) 523-1207	**7am-5pm weekdays**	
BEST/Boston Medical Center 818 Harrison Ave Boston, MA 02118 (800) 981-4357 (617) 414-7612 Fax (617) 414-4209	**24/7**	
BEST/Mass General Hospital 55 Fruit Street Boston, MA 02114 (800) 981-4357 (617) 726-2994 Fax (617) 724-3727	**24/7**	
BEST/Community Crisis Stabilization Program 20 Vining Street Boston, MA 02118 (800)981-4357 (617) 371-3000 Fax (617) 516-5071	**24/7**	
BEST Community Crisis Stabilization Program 85 E. Newton Street Boston, MA 02118 (800) 981-4357 (617) 371-3000 Fax (617) 414-8319	**24/7**	

Every ESP provides behavioral health crisis assessment, intervention and stabilization services, 24 hours per day/7 days per week/365 days per year, through 4 service components: Mobile Crisis Intervention (MCI) services for youth, adult mobile services, ESP community based locations, and community crisis stabilization (CCS) services for ages 18 and over. The operating hours for the ESP community based locations and CCS programs are noted above. The operating hours for Mobile Crisis Intervention services for youth are 24 hours per day/7 days per week at any and all locations. The operating hours for adult mobile services are 24 hours per day/7 days per week: during this time period, mobile services will be available from 7 a.m. to 8 p.m. at any/all locations, and from 8 p.m. to 7 a.m. this service will be available in residential programs and hospital emergency departments.

All ESP service components and locations may be accessed through the ESP's toll free number. Where applicable, local numbers for specific locations have also been provided above. It is recommended that individuals and families call the ESP's toll free number first, so the ESP can help them access the most appropriate services. Please refer to www.masspartnership.com and click on "ESP" on the left side of the homepage for more information including updates to this directory.

METRO BOSTON

Area: Cambridge Somerville **24 hour access number: 800-981-4357**

Provider: Boston Medical Center / Cambridge Somerville Emergency Services Team (C.S.E.S.T.)

ESP Director: Tasha Ferguson (617) 414-8379 Tasha.Ferguson@bmc.org Direct Fax: (617) 414-4769
Mobile Crisis Intervention Manager: TBD

Service Locations	Operating Hours	Cities/Towns in Area
CSESP Community Based Location 660 Broadway Somerville, MA 02145 800-981-4357 (617) 616-5111 Fax (617) 623-1817	**7am-11pm weekdays** **11am-7pm weekends**	Cambridge, Somerville
CSESP / Cambridge Hospital 1493 Cambridge Street Cambridge, MA 02139 800-981-4357 (617) 665-1560 Fax (617) 616-5410	**24/7**	
CSESP Community Crisis Stabilization Program 600 Broadway (617) 616-5472 800-981-4357 Fax (617) 623-1817	**24/7**	

Area: Norwood **24 hour access number: 800-529-5077**

ESP Provider: Riverside Community Care

ESP Director: Wen-Hui Yang (800)529-5077 wenhuiyang@riversidecc.org
Assistant ESP Director: Chia Hsuan Wu (800) 529-5077 chiahsuanwu@riversidecc.org
Mobile Crisis Intervention Manager: Erin Henry (781) 769-8674 ehenry@riversidecc.org

Riverside Community-Based Location 190 Lenox Street Norwood, MA 02062 (800) 529-5077 (781) 769-8674 Fax (781) 440-0740	**8am-8pm weekdays**	Canton, Dedham, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood, Wrentham
Riverside Community-Based Location 15 Beacon Ave Norwood, MA 02062 (800) 529-5077 (781) 769-8674 Fax (781) 769-6072	**8pm-8am weekdays** **24 hours weekends**	

Riverside Community Crisis Stabilization Program 15 Beacon Ave Norwood, MA 02062 (781) 769-1342 Fax (781) 769-0197	(800) 529-5077	**24/7**	
Area: South Shore	**24 hour access number: (800) 528-4890**		
ESP Provider: South Shore Mental Health (SSMH)			
Acting ESP Director: Kristin Woodbury (617) 774-6036 kwoodbur@ssmh.org **Mobile Crisis Intervention Manager:** TBD			
SSMH Community Based Location 460 Quincy Ave Quincy, MA 02169 617 774-6036 Fax (617) 479-0356	(800) 528-4890	**24/7**	Braintree, Cohasset, Hingham, Hull, Milton, Norwell, Quincy, Randolph, Scituate, Weymouth
SSMH Community Crisis Stabilization Program 460 Quincy Ave Quincy, MA 02169 617 774-6036 Fax (617) 479-0356	(800) 528-4890	**24/7**	

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WESTERN MASSACHUSETTS			
Area: The Berkshires	**24 hour access number: (800) 252-0227**		
ESP Provider: The Brien Center for Mental Health and Substance Abuse			
ESP Director: Rebecca Phelps (413) 629-1062 Rebecca.Phelps@briencenter.org **Mobile Crisis Intervention Manager:** Victoria Halsted (413) 629-1190 Victoria.Halsted@briencenter.org			
Service Locations		Operating Hours	Cities/Towns in Area
The Brien Center Community Based Location 34 Pomeroy Ave Pittsfield, MA 01201 (413) 499-0412 Fax (413) 499-0995	(800) 252-0227	**24/7**	Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesboro, Lee, Lenox, Monroe, Monterey, Mount Washington, New Ashford, New
The Brien Center Community Based Location 210 North Street Pittsfield, MA 01201 (413) 499-0412 Fax (413) 499-0995	(800) 252-0227	**8am-8pm** **7 days/ week**	

The Brien Center Community Based Location 124 American Legion Drive North Adams, MA 01247 (800) 252-0227 413-664-4541 Fax (413) 662-3311	**9am-5pm weekdays**	Marlboro, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy, Sheffield, Stockbridge, Tyringham, Washington, West Stockbridge, Williamstown, Windsor
The Brien Center Community Based Location 60 Cottage Street Great Barrington, MA 01230 (800) 252-0227 (413) 664-4541 Fax (413) 528-8187	**9am-5pm weekdays**	
The Brien Center Community Crisis Stabilization Program 34 Pomeroy Ave Pittsfield, MA 01201 (800) 252-0227 (413) 499-0412 Fax (413) 499-0995	**24/7**	
Area: Greenfield **24 hour access number: (800) 562-0112**		
ESP Provider: Clinical & Support Options		
ESP Director: Dan Sontag (413) 774-5411 dsontag@csoinc.org Fax: (413) 773-8429 **Mobile Crisis Intervention Manager:** Tanya Parker (413) 774-5411 tparker@csoinc.org		
Clinical & Support Options Community Based Location 140 High Street Greenfield, MA 01301 Greenfield, MA 01301 (800) 562-0112 413-774-5411 Fax (413) 773-8429	**24/7**	Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Millers Falls, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutebury, Sunderland, Turners Falls, Warwick, Wendell, Whately
Clinical & Support Options Community Based Location 491 Main Street Athol, MA 01331 (800) 562-0112 (978)249-9490 Fax (978) 249-3139	**8am-8pm weekdays**	
Clinical & Support Options Community Crisis Stabilization Program 140 High Street Greenfield, MA 01301 (800) 562-0112 413-772-0249 Fax (413) 773-8429	**24/7**	
Area: Northampton **24 hour access number: (800) 322-0424**		
ESP Provider: Clinical & Support Options		
ESP Director: Debra DeMuth (413) 586-5382, Ext. 3501 ddemuth@csoinc.org **Mobile Crisis Intervention Manager:** Amber Gahn (413) 586-5555 agahn@csoinc.org		
Service Locations	Operating Hours	Cities/Towns in Area
Clinical & Support Options Community Based Location 29 North Main Street Florence, MA 01062 (800) 322-0424 (413) 586-5555; Fax (413) 586-2723	**24/7**	Amherst, Chesterfield, Cumminton, Easthampton,

Clinical & Support Options Community Crisis Stabilization Program 29 North Main Street Florence, MA 01062 (413) 586-2973 Fax (413) 582-6893	(800) 322-0424	**24/7**	Florence, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, Worthington
Area: Southern Pioneer Valley	**24 hour access number: (800) 437-5922**		
ESP Provider: Behavioral Health Network			
ESP Director: Kate Hildreth-Fortin (413) 301-9350 kate.hildreth@bhninc.org **Mobile Crisis Intervention Manager:** Hallie-Beth Hollister (413) 271-8075 HallieBeth.Hollister@bhninc.org			
Behavioral Health Network Community Based Location 417 Liberty Street Springfield, MA 01104 (413) 733-6661 Fax (413) 733-7841	800-437-5922	**24/7**	Agawam, Belchertown, Blandford, Bondsville, Chester, Chicopee, East Longmeadow, Granby, Granville, Hampden, Holyoke, Huntington, Indian Orchard, Longmeadow, Ludlow, Monson, Montgomery, Palmer, Russell, South Hadley, Southampton, Southwick, Springfield, Thorndike, Three Rivers, Tolland, Ware, Westfield, West Springfield, Wilbraham
Behavioral Health Network Community Based Location **Carson Center** 77 Mill Street Westfield, MA 01085 (413) 568-6386 Fax (413) 572-4144	800-437-5922	**24/7**	
Behavioral Health Network Community Crisis Stabilization Program 417 Liberty Street Springfield, MA 01104 (413) 733-6661 Fax (413) 733-7841	800-437-5922	**24/7**	
Behavioral Health Network Community Crisis Stabilization Program **Carson Center** 77 Mill Street Westfield, MA 01085 (413) 568-6386 Fax (413) 572-4144	800-437-5922	**24/7**	
Behavioral Health Network Community Crisis Stabilization Program 40 Bobala Road Holyoke, MA 01104 (413) 532-8016 Fax (413) 532-8205	800-437-5922	**24/7**	

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CENTRAL MASSACHUSETTS		
Area: Metro West **24 hour access number: (800) 640-5432**		
ESP Provider: Advocates		
ESP Director: John DeRonck (508) 661-2043 jderonc@advocatesinc.org **ESP Director:** Kellan McNally (781) 893-2003 KmcNall@advocatesinc.org **Mobile Crisis Intervention Manager:** Kimberly Ward (508)620-0010 x109 kimberly_ward@waysideyouth.org		
Service Locations	**Operating Hours**	**Cities/Towns in Area**
Advocates Community Based Location 354 Waverly Street Framingham, MA 01702 (800) 640-5432 (508) 872-3333 Fax (508) 875-2600	**24/7**	Acton, Ashland, Arlington, Bedford, Belmont, Boxborough, Burlington, Carlisle, Concord, Framingham, Holliston, Hopkinton, Hudson, Lexington, Lincoln, Littleton, Maynard, Marlborough, Natick, Northborough, Sherborn, Southborough, Stow, Sudbury, Waltham, Watertown, Wayland, Westborough, Wilmington, Winchester, Woburn
Advocates Community Based Location 28 Mill Street Marlboro, MA 01752 (800) 640-5432 (508) 786-1584 Fax (508) 786-1585	**24/7**	
Advocates Community Based Location 675 Main Street Waltham, MA 02451 (800) 540-5806 (781) 893-2003 Fax (781) 647-0183	**24/7**	
Advocates Community Crisis Stabilization Program 28 Mill Street Marlboro, MA 01752 (800) 640-5432 (508) 786-1580	**24/7**	
Area: North County **24 hour access number: (800) 977-5555**		
ESP Provider: Community HealthLink Inc.		
ESP Director: Julie Orozco (508) 373-7982 jorozco@communityhealthlink.org **Mobile Crisis Intervention Manager:** Wendy Martel (978) 840-9340 wmartel@communityhealthlink.org		
Community HealthLink, Inc. Community Based Location 40 Spruce Street Leominster, MA 01453 (800) 977-5555 (978) 534-6116 Fax (978) 537-4966	**24/7**	Ashburnham, Ashby, Ayer, Barre, Berlin, Bolton, Clinton, Fitchburg, Gardner, Groton, Hardwick, Harvard, Hubbardston, Lancaster, Leominster, Lunenburg, New Braintree, Oakham, Pepperell, Princeton, Rutland, Shirley, Sterling, Templeton, Townsend, Westminster, Winchendon
Community HeatlhLink Community Crisis Stabilization Program 40 Spruce Street Leominster, MA 01453 (800) 977-5555 (978) 534-6116 Fax (978) 534-3294	**24/7**	
Area: South County **24 hour access number: (800) 294-4665**		
ESP Provider: Riverside Community Care		
ESP Director: Amanda Rutherford (508)634-3420 arutherford@riversidecc.org **Assistant ESP Director:** Shannon Cassidy (508) 634-3420 scassidy@riversidecc.org **Mobile Crisis Intervention Manager:** Chris Lauzon (508) 634-3420 clauzon@riversidecc.org		
Service Locations	**Operating Hours**	**Cities/Towns in Area**

Riverside Community Based Location 32 Hamilton Street Milford, MA 01757 (800) 294-4665 (508) 634-3420 Fax (508) 422-9644	**24/7**	Bellingham, Blackstone, Brimfield, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Holland, Hopedale, Medway, Mendon, Milford, Millville, Northbridge, North Brookfield, Oxford, Southbridge, Sturbridge, Sutton, Upton, Uxbridge, Wales, Warren, Webster, West Brookfield
Riverside Community Based Location 206 Milford Street Upton, MA 01568 (800) 294-4665 (508) 529-7000 Fax (508) 529-7001	**8am-5pm weekdays**	
Riverside / Harrington Memorial Hospital 100 South Street Southbridge, MA 01550 (800) 294-4655 (508) 765-3035 Fax (508) 764-2434	**8am-8pm 7 days / week**	
Riverside Community Based Location **GB Wells Center** 29 Pine Street Southbridge, MA 01550 (800) 294-4655 (508) 765-9167 Fax (508) 764-2434	**TBD**	
Riverside Community Crisis Stabilization Program 32 Hamilton Street Milford, MA 01757 (800) 294-4665 (508) 634-3420 Fax (508) 422-9644	**24/7**	
Area: Worcester 24 hour access number: (866) 549-2142		
ESP Provider: Community Healthlink Inc.		
ESP Director: Jeanne Daniels (978) 401-3820 jdaniels@communityhealthlink.org **Mobile Crisis Intervention Manager:** Lori Simkowitz-Lavigne (774) 312-2472 lsimkowitz-lavigne@communityhealthlink.org		
UMASS Community Based Location **Community HealthLink** 72 Jaques Ave Thayer Building, 2nd floor Worcester, MA 01610 (866) 549-2142 (508) 860-1283 Fax (508) 856-1695	**24/7**	Auburn, Boylston, Grafton, Holden, Leicester, Milbury, Paxton, Shrewsbury, Spencer, West Boylston, Worcester
UMASS Memorial Medical Center 55 Lake Avenue North Worcester, MA 01655 (866) 549-2142 (508) 334-3562 Fax (508) 856-1695	**24/7**	
UMASS Community Crisis Stabilization Program 72 Jaques Ave Thayer Building, 2nd floor Worcester, MA 01610 (866) 549-2142 (508) 860-1283; Fax (508) 856-1695	**24/7**	

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NORTHEASTERN MASSACHUSETTS

Area: North Essex **24 hour access number: (866) 523-1216**

ESP Provider: Lahey/Northeast Behavioral Health

ESP Director: Andrea Hall (978) 744-1585 ahall@nebhealth.org
Assistant ESP Director: TBD
Mobile Crisis Intervention Manager: Ellen Jarmusik (978) 744-1585 ejarmusik@nebhealth.org
Mobile Crisis Intervention Manager: Haskell Brooks (978) 521-7777 hbrooks@nebhealth.org

Service Locations	Operating Hours	Cities/Towns in Area
Lahey/NBH Community Based Location 62 Brown St, Suite 305 Haverhill, MA 01830 (800) 281-3223 978-521-7777 Fax (978)521-7767	**8am-8pm M-Th** **8am-5pm Fri**	Amesbury, Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Groveland, Hamilton, Haverhill, Ipswich, Manchester by the Sea, Marblehead, Merrimac, Middleton, Newbury, Newburyport, Peabody, Rockport, Rowley, Salem, Salisbury, Topsfield, Wenham, West Newbury
Lahey/NBH Community Based Location 41 Mason Street, Unit #4 Salem, MA 01970 (866) 523-1216 978-744-1585 Fax (978) 744-1379	**24/7**	
Lahey/NBH / Salem Hospital - North Shore Medical Center 81 Highland Avenue Salem, MA 01970 (866) 523-1216 (978) 354-4550 Fax (978) 745-9021	**24/7**	
Lahey/NBH Community Crisis Stabilization program 41 Mason Street, Unit #4 Salem, MA 01970 (866) 523-1216 978-744-1585 Fax (978) 744-1379	**24/7**	

Area: Lawrence **24 hour access number: (877) 255-1261**

ESP Provider: Lahey/Northeast Behavioral Health

ESP Director: Tom Draper (978) 620-1250 tdraper@nebhealth.org
Mobile Crisis Intervention Manager: Mel Moran (978) 620-1250 mmoran@nebhealth.org

NBH Community Based Location 12 Methuen Street 2nd Floor Lawrence, MA 01841 (877) 255-1261 (978)-620-1250 Fax (978) 682-9333	**8am-12am** **7 days / week**	Andover, Lawrence, Methuen, North Andover

NBH Community Crisis Stabilization Program 12 Methuen Street 2nd Floor Lawrence, MA 01841 (978)-620-1250 Fax (978) 682-9333	(877) 255-1261	**24/7**	
Area: Lowell	**24 hour access number: (800) 830-5177**		
ESP Provider: Lahey/Northeast Behavioral Health			
ESP Director: Colleen Babson (978)455-3397 cbabson@nebhealth.org **Mobile Crisis Intervention Manager:** Nancy Vukmirovits (978)455-3397 nvukmirovits@nebhealth.org			
Lahey/NBH Community Based Location 391 Varnum Ave Lowell, MA 01854 978-322-5120 Fax (978) 322-5134	(800) 830-5177	**8am-8pm** **7 days / week**	Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsboro, Westford
Lahey/NBH Community Crisis Stabilization Program 391 Varnum Ave Lowell, MA 01854 978-322-5120 Fax (978) 322-5134	(800) 830-5177	**24/7**	
Area: Tri-City	**24 hour access number: (800) 988-1111**		
ESP Provider: Eliot Community Services			
ESP Director: TBD **Mobile Crisis Intervention Manager:** Donna Kausek (781) 581-4493 dkausek@eliotchs.org			
Eliot Community Based Location 95 Pleasant Street Lynn, MA 01901 (781) 596-9222 Fax (781) 581-9876	(800) 988-1111	**8am-8pm weekdays** **9am-6pm weekends**	Everett, Lynn, Lynnfield, Malden, Medford, Melrose, Nahant, North Reading, Reading, Saugus, Stoneham, Swampscott, Wakefield
Eliot Community Based Location 173 Chelsea Street Everett, MA 02149 (781) 388-6220 Fax (781) 581-9876	(800) 988-1111	**8am-8pm weekdays** **9am-6pm weekends**	
Eliot Community Crisis Stabilization Program 95 Pleasant Street Lynn, MA 01901 (781) 596-9222 Fax (781) 581-9876	(800) 988-1111	**24/7**	

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SOUTHEASTERN MASSACHUSETTS		
Area: Southern Coast **24 hour access number: (877) 996-3154**		
ESP Provider: Child and Family Services of New Bedford		
Acting ESP Director: Rebecca Pye (508) 996-3153 rpye@cfservices.org **Mobile Crisis Intervention Manager:** Mary Canha (508)996-3154 mcanha@cfservices.org		
Service Locations	**Operating Hours**	**Cities/Towns in Area**
Child and Family Services Community Based Location 543 North Street New Bedford, MA 02740 (877) 996-3154 508-996-3154 Fax (508) 991-8082	**24/7**	Acushnet, Carver, Dartmouth, Duxbury, Fairhaven, Halifax, Hanover, Hanson, Kingston, Marion, Marshfield, Mattapoisett, New Bedford, Pembroke, Plymouth, Plympton, Rochester, Wareham
Child and Family Services Community Based Location 118 Long Pond Rd, Ste 102 Plymouth, MA 02367 (877) 996-3154 508-747-8834 Fax (508) 747-8835	**24/7**	
Child and Family Services Community Crisis Stabilization Program 543 North Street New Bedford, MA 02740 (877) 996-3154 508-996-3154 Fax (508) 991-8082	**24/7**	
Area: Brockton **24 hour access number: (877) 670-9957**		
ESP Provider: *Brockton Multi-Service Center		
ESP Director: Merleen Mills (508)285-9400 merleen.mills@massmail.state.ma.us **Mobile Crisis Intervention Manager:** Valencia Dailey-Reid (508) 897-2100 valencia.reid@massmail.state.ma.us **Mobile Crisis Intervention Director** Jennifer Paine (508) 977-3346 jennifer.paine@massmail.state.ma.us		
Brockton Multi-Service Center Community Based Location 165 Quincy Street Brockton, MA 02302 (877) 670-9957 508-897-2100 Fax (508) 586-5117	**24/7**	Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Holbrook, Pocasset, Rockland, Stoughton, West Bridgewater, Whitman
Brockton Multi-Service Community Crisis Stabilization Program 165 Quincy Street Brockton, MA 02302 (877) 670-9957 508-897-2100 Fax (508) 586-5117	**24/7**	
Area: Cape Cod and The Islands **24 hour access number: (800) 322-1356**		
ESP Provider: *Cape & Islands Emergency Services		
ESP Director: TBD **Mobile Crisis Intervention Manager:** Marc Pizzuto (508) 564-9690 marc.pizzuto@massmail.state.ma.us **Mobile Crisis Intervention Director:** Jennifer Paine (508) 977-3346 jennifer.paine@massmail.state.ma.us		
Cape Cod Community Based Location 830County Road Pocasset, MA 02559 (800) 322-1356 (508) 564-9690 Fax (508) 564-9699	**24/7**	Aquinnah, Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham,

Cape Cod Community Crisis Stabilization Program **May Institute** 270 Communication Way, Unit 1E Hyannis, MA 02601 (800) 322-1356 (508) 790-4094 Fax (508) 362-5647	**24/7**	Edgartown, Falmouth, Gay Head, Gosnold, Harwich, Hyannis, Mashpee, Nantucket, Oak Bluffs, Orleans, Osterville, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Woods Hole, Yarmouth
Area: Fall River 24 hour access number: (877) 425-0048		
ESP Provider: *Corrigan Mental Health Center		
ESP Director: Alison Hathaway (508) 235-7277 alison.hathaway@massmail.state.ma.us **Mobile Crisis Intervention Manager:** Amy Raff (508) 235-7277 amy.m.raff@massmail.state.ma.us **Mobile Crisis Intervention Director:** Jennifer Paine (508) 977-3346 jennifer.paine@massmail.state.ma.us		
Corrigan Mental Health Center Community Based Location 49 Hillside Street Fall River, MA 02720 (877) 425-0048 (508) 235-7277 Fax (508) 235-7345	**24/7**	Assonet, Fall River, Freetown, Somerset, Swansea, Westport
Area: Taunton / Attleboro 24 hour access number: (800) 660-4300		
ESP Provider: *Norton Emergency Services		
ESP Director: Merleen Mills (508) 285-9400 mmills02@massmail.state.ma.us **Mobile Crisis Intervention Manager:** Susan Gill-Hickey (800) 660-4300 susan.gill-hickey@massmail.state.ma.us **Mobile Crisis Intervention Director:** Jennifer Paine (508) 977-3346 jennifer.paine@massmail.state.ma.us		
Taunton / Attleboro Emergency Service Community Based Location 108 West Main St., Bldg. #2 Norton, MA 02766 (800) 660-4300 (508) 285-9400 Fax (508) 285-6573	**24/7**	Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleborough, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, Taunton
Taunton / Attleboro Community Crisis Stabilization Program 108 West Main St., Bldg. #2 Norton, MA 02766 (800) 660-4300 (508) 285-9400 Fax (508) 285-6573	**24/7**	

*** DMH Operated ESP**

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Exhibit 2: **State-Operated Community Mental health Centers**

Fuller/Bay Cove Community Mental Health Center CMHC/Boston Campus 85 East Newton Street Boston, MA 02118
Brockton Multi-Service Center 165 Quincy Street Brockton, MA 02402
Erich Lindemann Mental Health Center 25 Staniford Street Boston, MA 02114
H.C. Solomon Mental Health Center 391 Varnum Avenue Lowell, MA 01854
John C. Corrigan Mental Health Center 49 Hillside Street Fall River, MA 02729
Mass. Mental Health Center 180 Morton Street Jamaica Plain, MA 02130
Pocasset Mental Health Center 830 Country Road Pocasset, MA 02559
Quincy Mental Health Center 460 Quincy Avenue Quincy, MA 02052

Exhibit 3: State Operated Facilities Providing Inpatient Mental Health Services, Outpatient Behavioral Health Services, and Diversionary Behavioral Health Services

Type of Service/Appendix C Category	Provider Name	Location	NPI	Claim Form[1]	Service	Notes
Hospital Based Services	Cape Cod and Islands Mental Health Center	Pocasset	1851477491	UB04	Inpatient Services	
Hospital Based Services	Corrigan Mental Health Center	Fall River	1700964947	UB04	Inpatient Services	
Hospital Based Services	Corrigan Mental Health Center	Fall River	1194803288	UB04	Outpatient Services*	
Hospital Based Services	Cape Cod and Islands Mental Health Center	Pocasset	1851477491	1500	Professional Services	
Hospital Based Services	Corrigan Mental Health Center	Fall River	1700964947	1500	Professional Services	
Diversionary Services	Brockton MultiService Center	Brockton	1326155458	1500	ESP/Community Crisis Stabilization	closing by 6/30/17
Diversionary Services	Cape Cod and Islands Mental Health Center	Pocasset	1740359611	UB04	ESP/Community Crisis Stabilization*	closing by 6/30/17
Diversionary Services	Corrigan Mental Health Center	Fall River	1194803288	UB04	ESP/Community Crisis Stabilization*	closing by 6/30/17
Diversionary Services	Brockton MultiService Center	Brockton	1326155458	UB04 or 1500	Crisis Stabilization Bed	
Diversionary Services	Cape Cod and Islands Mental Health Center	Pocasset	1740359611	UB04	Partial Hospitalization*	
Diversionary Services	Corrigan Mental Health Center	Fall River	1194803288	UB04	Partial Hospitalization*	
Diversionary Services	MassMental Health Center	Boston	1568587913	UB04	Partial Hospitalization*	Closed
Diversionary Services	Substance Abuse Program "WRAP"	Taunton	1508212416	1500	Acute Treatment Services	
Diversionary Services	Substance Abuse Program "WRAP"	Taunton	1508212416	1500	Clinical Support Services	
Clinic services	Brockton MultiService Center	Brockton	1326155458	1500	Clinic	
Clinic services	MassMental Health Center	Boston	1073638805	1500	Clinic	

[1] Professional services are also billed for these programs on a 1500 claim form.

Exhibit 4: Public and Private Institutions for Mental Disease (IMD)[2]

Private IMDs – Inpatient Hospital Services
(As of January 2017)

Provider ID	Hospital Name	NUM_TAX_ID	Provider Type
110026750A	Adcare Hospital of Worcester	042053042	74
110027427B	Baldpate Hospital	042392742	73
110027417A	McLean Hospital (Partners HealthCare)	042697981	73
110027414A	Bournewood Hospital	042844287	73
110027437A	Walden Behavioral Care	200060125	73
110027416A	Arbour Hri Hospital Inc	232238958	73
110020804E	Arbour Hospital	232238962	73
110027393A	Lowell Treatment Center		73
110027429A	UHS OF FULLER INC	232801395	73
110027393A	Westwood Lodge Hospital	233061361	73
110027393A	Pembroke Hospital		73
110027404C	Whittier Pavilion		73
110032615B	Hampstead Hospital (NH)		73
110105912B	Southcoast Behavioral Health		73
pending	TaraVista - already contracted with MBHP, waiting Medicare cert for FFS		*pending*
110028153T	High Point Treatment Center		73

Public IMDs - State-Owned Non-Acute Hospitals Operated by the Department of Mental Health
(As of June 2014)

Provider ID	DMH Hospital Name
110000091G	SC Fuller Mental Health Center
110000084H	Taunton State Hospital
110000091D	Worcester State Hospital

[2] In accordance with 42 CFR 438.3(e)(2) and 438.6(e)

APPENDIX H

COORDINATION OF BENEFITS REQUIREMENTS

The following describes the activities and requirements for ensuring that all eligible Enrollees are appropriately enrolled into the Contractor's Plan.

The Contractor shall designate a Third Party Liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract. The Benefit Coordinator will be responsible for meeting with EOHHS when deemed necessary by EOHHS's Benefit Coordination and Recovery Unit.

I. Third Party Health Insurance Identification and Cost Avoidance

The Contractor shall develop procedures and train its staff to ensure that Enrollees who have other insurance are either (1) not enrolled into the Contractor's Plan if third party health insurance is identified and verified prior to enrollment, or (2) disenrolled by EOHHS upon third party health insurance verification post enrollment. The three possible types of third party health insurance are Commonwealth Care, the Contractor's own commercial product or a third party commercial health insurance product. When directed by EOHHS, the Contractor shall include on the Daily Inbound Demographic Change file, or on the TPL Indicator form until the Daily Inbound Demographic Change file is implemented, Enrollees who, after enrollment, are found to have other active health insurance coverage.

Once an Enrollee is identified as having other health insurance, the Contractor must cost avoid claims for which another insurer may be liable, except in the case of prenatal and EPSDT services per 42 USC 1396a(a)(25)(E) and 42 CFR 433.139.

If the Enrollee is found to be enrolled in the Contractor's commercial plan or Commonwealth Care, as applicable, the Enrollee's information shall be sent to EOHHS or its designee. Upon receipt of the information, if Commonwealth Care is the other health insurance, EOHHS shall disenroll the Enrollee from the Contractor's Plan effective the date the third party health insurance is verified and entered into MMIS. If the Contractor's commercial health insurance product is the other insurance, EOHHS shall disenroll the Enrollee from the Contractor's Plan effective the "TPL effective date" in MMIS.

The Contractor shall identify and communicate with EOHHS or its designee the existence of other health insurance through the following methods and procedures:

A. The Contractor shall report suspected TPL on the daily Inbound Demographic Change file after the daily Inbound Demographic Change file is implemented, or on the TPL Indicator form provided by EOHHS and sent to EOHHS's TPL Unit prior to implementation.

B. The Contractor shall require their Providers to send any other health insurance information found about its Enrollees to the Contractor.

C. The Contractor shall provide a TPL Indicator form, approved by EOHHS, to their Providers for use in communicating to the Contractor the liable third party insurance information for their Enrollees. This form may be distributed at network trainings performed by the Contractor.

D. The Contractor shall review claims data received from their Providers for indications of other liable insurance coverage. The Contractor shall send the other health insurance information to EOHHS or its designee.

II. Third Party Health Insurance Recovery

A. The Contractor shall implement procedures to (1) determine if a potential Enrollee has other health insurance and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:

1. The HIPAA 834 Outbound Daily file ;
2. Claims Activity;
3. Point of Service Investigation (Customer Service, Member Services and Utilization Management); and
4. Any TPL information self reported by an Enrollee.

B. At a minimum, such procedures shall include:

1. Performing a data match against the Contractor's subscriber/member list for any other product line it offers and providing this information to EOHHS or its designee; and
2. Reviewing claims for indications that other insurance may be active (e.g. explanation of benefit attachments or third party payment).

C. If a claim is processed for payment and it is later determined that another carrier should have been the primary payor, the Contractor shall give the Provider the other insurance information the Contractor obtained through data matching Enrollees. The Contractor shall work with the Provider to ensure that this information is used for any further billing of claims for said Enrollee. In addition, the Contractor shall pursue recoveries for previously paid claims by, as appropriate, pursuing demand billing and overpayment recovery.

III. Reporting

The Contractor shall develop, at a minimum, the report identified in **Appendix A**. The Contractor shall meet with EOHHS to clarify the content of the semi-annual report listed below:

A. Health Insurance Referrals – the number of members identified as having TPL on the HIPAA 834 Outbound Full file.

B. Cost avoidance – Claims that were denied due to the existence of another health insurance plan on a monthly and semi-annual basis. The dollar amount per Member that was cost avoided on the denied claim.

C. Recovery – Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan. The dollar amount recovered per Member from the other liable insurance carrier or Provider.

IV. Accident and Third Party Liability Identification and Recovery

A. Identification

1. Claims Editing

The Contractor shall have claims editing and reporting procedures in place to identify potential accident and casualty cases, including but not limited to the following:

Screening Diagnosis Codes for Trauma. The Contractor shall identify Enrollees who are suspected of having suffered an injury as a result of an accident or other loss. Enrollees' names are pulled from the claims system using an automated system of selection and retrieval. The selection criterion is based on a predetermined diagnosis code range of all claims sent to the Contractor. The Contractor shall verify that an accident occurred either by contacting the Enrollee or by using an information data warehouse.

2. Sharing of TPL Information/Accident Referrals

If the Contractor receives claims information from their Providers indicating that certain medical services are being provided as a result of an accident or other loss, the Contractor shall require their Providers to furnish all necessary information that will allow the Contractor to pursue the Accident/Recovery or Cost Avoidance.

B. Accident/Casualty Recovery and Cost Avoidance of Claims

The Contractor shall perform the following activities to recover or cost-avoid claims where an Enrollee has been involved in an accident or lawsuit.

1. Cost-Avoidance

The Contractor shall have the following processes in place to cost avoid claims, except in the case of prenatal and EPSDT services where the Contractor shall pay and recover later per 42 USC 1396a(a)(25)(E) and 42 CFR 433.139.

a. On all automobile cases, providing the Enrollee cooperates with the Contractor and signs the necessary paperwork, the Contractor shall process accident claims for payment and submit insurance claims to the no-fault carrier for the $8,000 PIP (personal injury protection) benefit. If possible, cases involving PIP should be cost avoided up front. After the $8,000 is exhausted, the Contractor becomes the primary payer for any future services, unless there is other third party insurance available.

b. Claims are denied for Enrollees who do not provide the Contractor with the necessary automobile information when it has been noted that an Enrollee has been involved in an automobile accident.

c. On all workers' compensation cases, the Contractor shall contact the employer to verify that an injury is work related, and also contact the worker's compensation carrier to determine whether the case has been accepted. All claim information is then entered into the system. If liability has been established, then the Contractor retracts all claims that relate to the accident and sends a letter to the Provider detailing the claims being retracted and whom to bill. If the case has not been accepted, then the Contractor takes appropriate steps to lien the case if necessary.

d. Any referral entered into the system that may be trauma related is flagged in a way that prompts the Claims department to pend the claim to the Recovery Department for review.

2. Recovery

If the Enrollee cooperates and supplies the Contractor with the necessary information, subrogation claims are processed for payment and a lien is filed on the case.

a. If the accident is work related:

Upon discovery that the worker's compensation case is not an accepted case, meaning that liability has not been established, and given that the Enrollee cooperates and supplies the Contractor with the necessary information, subrogation claims are processed for payment and a lien is filed on the case.

b. Other accidents or losses (i.e., general liability, medical malpractice, etc.):

If the Enrollee cooperates and supplies the Contractor with the necessary information, subrogation claims are processed for payment and a lien is placed on the case.

3. Reporting

On a semi-annual basis, the Contractor shall provide EOHHS with an ongoing status report on all Enrollees identified as having had an accident or other loss. The report shall include the following information for each Enrollee who has been identified as receiving medical services as the result of an accident, injury, or has filed a lawsuit related to an accident or injury.

a. General Information

(1) Enrollee name;
(2) Enrollee's MassHealth or SSN number;
(3) Date of referral to EOHHS;
(4) Date of accident;
(5) Type of accident; and
(6) Status (i.e., lien, cost avoided)

b. Cost Avoidance: amount cost avoided (i.e. PIP payments)

c. Recovery

(1) Recovery Source
(2) Amount of lien;
(3) Amount of settlement (if available);
(4) Amount collected (if available); and
(5) Amount compromised.

See **Appendix A** for a sample of the required report to be sent to EOHHS.

4. EOHHS Recovery

EOHHS is entitled to recover the amount paid by the Contractor for medical services provided to the Enrollee in accordance with M.G.L. c. 118E § 22, in the event EOHHS determines the Contractor failed to make, in EOHHS' judgment, a timely subrogation claim or assert a lien on the related settlement, court order, judgment or payment and EOHHS receives an inquiry through the Massachusetts Department of Revenue's Payment Intercept Program (PIP) under M.G.L. c.175, §24D and §24E. If EOHHS seeks to enforce its right to recover such payments, EOHHS shall notify the Contractor and the Contractor shall provide requested medical claims data to EOHHS or its designee within three (3) business days of the request for such information. EOHHS shall have no liability to the Contractor for any amounts recovered by EOHHS.

Notwithstanding the foregoing, EOHHS may recover other amounts permitted under law, including but not limited to M.G.L. c.18 § 5G and M.G.L. c.118E §69 (a)(2).

V. TPL Recoveries Factored into Capitation Rate Development

EOHHS expects the Contractor to recover claims paid to its Providers where the other insurer was primary. EOHHS will factor TPL recoveries into the annual capitation rate development process.

APPENDIX I

MATERIAL SUBCONTRACTOR CHECKLIST

Below is a list of questions related to [***insert name of MCE***] preparedness for entering into a contract with a Material Subcontractor [***Insert name and type of subcontractor***]. **The Contractor shall provide a written response to these questions no later than 60 days prior to contract execution.**

Name of MCE:_____ Date of Submission:_____

Date of Resubmissions (if applicable): _____

SECTION 1

Please answer all questions completely. If a question is not applicable, insert N/A throughout.

GENERAL INFORMATION

1. What is the name of the Material Subcontractor?
2. What is the type and scope of service to be provided by the Subcontractor (e.g. PBM, Behavioral Health, claims processing, care management, mail order pharmacy)?
3. What is the expected effective date of the Subcontract?
4. What is the expected date on which the Subcontractor will begin to deliver services, if different from the expected effective date of the Subcontract (due to ramp up time or other implementation factors)?
5. What are the key reasons for choosing to contract with Subcontractor to perform these activities?
6. What are the key reasons for selection of this Subcontractor?
7. What are the primary services that this Subcontractor will perform, including the business functions, and/or the range of health conditions on which this Subcontractor will focus?
8. What specific services will the Subcontractor provide? If comparable services are to be provided by the MCE, how will the services provided by this Subcontractor differ from those provided by MCE and why are such redundancies necessary?
9. Confirm that the MCE has ensured and explain how the MCE has ensured that the Subcontractor is financially sound.

SUBCONTRACTOR REIMBURSEMENT

10. How will the Subcontractor be reimbursed? If reimbursement is on a PMPM, will the reimbursement be based on enrollees referred or enrollees served? If based on enrollees served, please provide a definition of "served" in this respect.

11. Provide a summary of the ROI review conducted to justify the anticipated gains and potential cost savings as an offset to the increased administrative expenditure.

MCE STAFF TRAINING AND COORDINATION

12. How and when will MCE Enrollee Services and all other MCE business units' staff be trained about the Subcontractor?

13. Submit copies of the relevant training materials.

14. Will the MCE designate staff to interact with the Subcontractor? If so, which staff and how many will be designated? Will interactions between staff and the Subcontractor take place in-person or remotely or both?

15. Specify the nature of coordination and communication that will occur between the Subcontractor and MCE staff.

16. Describe the nature of communication and coordination, and transfer of information, between this Subcontractor and other Subcontractors, as applicable, for each of the above listed interactions. Include the role of the MCE for each.

NOTIFICATION OF AND EFFECTS ON ENROLLEES (IF APPLICABLE)

17. How many Enrollees in total will the Subcontractor serve? How will Enrollees be identified for this service?

18. Will the Subcontractor operations be visible or transparent to Enrollees?

19. How and when will existing Enrollees be notified of the role and availability of the Subcontractor? **Submit draft copies of the relevant notification letters/materials.**

20. Will new Enrollee identification cards be sent? If so, how and when?

21. Identify any differences in access to Enrollee services that may result from having this Subcontractor and, if access is more limited, the nature and timing of outreach to Enrollees.

22. Describe any other anticipated effects of the Subcontractor's on Enrollees' engagement with the MCE.

NOTIFICATION OF AND EFFECTS ON PROVIDERS (IF APPLICABLE)

23. Will the Subcontractor operations be visible or transparent to Providers?

24. How and when will the MCE provider network be informed about the Subcontractor? **Please submit draft copies of the relevant notification and training materials.**

25. How will the MCE ensure that PCPs are aware and approving of any information that the Subcontractor presents to Enrollees?

26. Identify any differences in access to Provider services that may result from having this Subcontractor and, if access is more limited, the nature and timing of outreach to Providers.

27. Describe any other anticipated effects of the Subcontractor on Providers.

SYSTEMS/ DATA

28. Will the Subcontractor have retrospective or live access to any MCE systems? If so, which system(s)?

29. Describe data elements to be shared between the Subcontractor and the MCE.

30. Describe the process for data sharing between the Subcontractor and the MCE.

31. How will data generated by the Subcontractor be integrated into MCE system(s), if applicable? How will data in the MCE system be transferred to the Subcontractor, if applicable? What will be the frequency of such integration? How will data integrity be ensured? Explain the arrangement that will ensure the Enrollee has the full range of recourse via the grievance and appeal system, including timely notifications and resolutions of processes.

32. Describe any expected loss of data history due to implementation of the Subcontract, if any.

33. Describe how the MCE will manage any unanticipated loss of data/information due to implementation of the Subcontract.

34. Does the MCE intend to operate redundant IT systems before a new system is relied upon solely? If so, for how long and how will the MCE manage such redundancy of systems?

35. Describe the process that will be used to ensure that the IT system will have capacity to interface with New MMIS effectively, as applicable.

READINESS REVIEW

36. Describe the readiness review that the MCE will conduct of the Subcontractor, including timeframes.

37. Provide the MCE's contingency plan should the Subcontractor not be ready to operate by the expected implementation date. At what point will this contingency plan be implemented?

38. Has the Subcontractor worked with MassHealth or other Medicaid populations and/or within the MA market? If so, address prior experiences and measures of performance, including results of services implemented, if known.

39. Describe the training and education that the MCE will provide to the Subcontractor regarding the MCE and the MassHealth population.

EVALUATION

40. Describe how the Subcontractor's performance will be evaluated. Does the MCE plan to evaluate the Subcontractor, or will the Subcontractor conduct the evaluation independently? If the Subcontractor will self-evaluate, what role, if any, will the MCE play in the evaluation?

41. How will the MCE ensure effective Subcontractor participation in all EQRO related activities?

42. How will the MCE ensure the Subcontractor's compliance with all MassHealth MCE Program contractual provisions, including those relating to confidentiality of information and Marketing?

43. Reference any national, state, and/or local standards to which the Subcontractor will adhere.

SECTION 2

Please answer all questions completely within the area below that are applicable to the new Subcontractor type.

Behavioral Health Subcontractor:

1. What are the MCE's reasons for deciding to subcontract for some or all of its behavioral health operations?

2. Describe the MCE's planned management structure of the behavioral health carve-out vendor.

3. How will the behavioral health material subcontract support the integration of physical and behavioral medical care management? How will care management be structured for enrollees with both medical and behavioral health issues that require care management?

PBM:

What are the MCE's key reasons for selecting this PBM, or switching from the current PBM?

Mail Order Pharmacy:

1. What are the key reasons for proposing a Mail Order Pharmacy (MOP) program?

2. Provide an overview and description of the proposed MOP program.

3. Provide a list of the therapeutic drug categories and covered drugs that will be included and excluded in the MOP program, along with a description of the inclusion/exclusion criteria. Describe the process that will be used to monitor and mitigate inappropriate early refills. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

4. Describe the process that will be used to minimize the risk of drug diversion. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

5. Describe the process that will be used to provide emergency access (i.e. weekends, after hours, vacation, etc.) if a enrollee does not receive the prescription drug in a timely manner. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

6. Describe the process that will be used to ensure that enrollees are fully informed and provided an opportunity to raise questions and concerns regarding the risks and side effects of the drugs received through the MOP Program. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

7. Describe the process that will be used to ensure that a enrollee will not be denied medications as a result of not paying a copayment. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

Care Management:

1. Describe the process that will be used to transfer the active caseloads of enrollees currently receiving Care Management from the MCE and/or other Subcontractor to the new Subcontractor.

2. Describe the process that will be used to ensure minimal disruption to enrollees and/or care management systems. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

3. Describe the process that will be used to ensure effective communication and coordination between the Subcontractor, PCPs of enrollees in care management, and the MCE. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?

Utilization Management

Describe the mechanisms it will use to ensure that subcontractor managed levels of service utilization are appropriate and simultaneously ensure high quality care in a manner that would not impede access to medically necessary care.

Claims:

1. Describe the process that will be used to transfer the current claims processing system to the new claims processing system.
2. Describe the process that will be used to ensure minimal disruption to claims processing and other IT functions, including timely and appropriate payment of claims. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?
3. Describe the process that will be used to ensure that any prior approvals granted under the current system will be honored under the Subcontractor.
4. Describe the process that will be used to ensure that claims will not be double-paid by the current and the new Subcontractor during transition. What are the respective roles of the Subcontractor and the MCE in this process, and the nature of communication and collaboration between the Subcontractor and the MCE in this process?
5. Explain what steps will be taken to be sure the new claims system can properly perform all the interfaces with MMIS that are required.
6. Describe steps to ensure MassHealth reporting will not be negatively impacted

Call Center

1. Describe the process for handling various types of calls from MassHealth enrollees.
2. Is a separate entity responsible for handing calls for MassHealth Enrollees, prospective enrollees, and/or enrollees in other product lines? If so, what is the nature of referral and coordination between the Subcontractor(s) and MCE?
3. Please describe how the process for handling various types of calls differs for MassHealth enrollees, prospective enrollees, and/or enrollees in other product lines, if applicable
4. How will the MCE ensure that all required enrollee notifications occur in a timely and effective manner?

Other Comments:

Appendix J

MMIS Interfaces with Managed Care Organizations (MCOs)

All Interfaces from, or to, a Managed Care Organization (MCO) and MMIS have been defined as batch interfaces (as opposed to transactional).

All HIPAA transactions will be in **X12 format**. All non-HIPAA interfaces will be in **XML format**.

Appropriate Channels for interfacing of batch transactions include:

1. Health Transaction Service (HTS); and
2. Provider Web Portal

Listed below is a short description of each of the interfaces from, or to, MMIS and the MCOs. Note that the terms INBOUND and OUTBOUND are used to denote the flow of data relative to MMIS. Inbound is data coming from an MCO to MMIS, and outbound is data coming from MMIS to an MCO.

A. Inbound Interfaces

1. Inbound Managed Care Provider Directory

   On a monthly basis, the Contractor shall submit to MMIS a full listing of its Primary Care Provider Network to be loaded into a Managed Care Provider directory database. This database will be used to support Member enrollment choices. Information such as the provider type and specialties, working hours, languages spoken and handicap accessibility will be supplied to Members based on the information in the directory.

   This file may include additional specialties as further directed by EOHHS.

2. Inbound Co-Pay Data

   On a daily basis, the Contractor shall transmit co-pay information on Enrollees to MMIS.

B. Outbound Interfaces

1. HIPAA 834 Outbound Daily File

   On a daily basis, MMIS will transmit the HIPAA 834 enrollment transactions to the Contractor. The 834 is the mechanism by which MMIS communicates to MCOs any changes in Enrollee name, DOB, gender, address, Medicare, enrollment dates and member enrollment changes.

2. HIPAA 834 Outbound Monthly File

   On a monthly basis, MMIS will transmit a full set of all enrollment transactions to the Contractor. This gives the Contractor a mechanism to verify that its enrollment files and MMIS enrollment

files are synchronized. This audit file will send the most current information available which will include any Enrollee updates that took place during the previous month.

3. HIPAA 820 File

   On a scheduled monthly basis, MMIS will transmit HIPAA 820 payment confirmations.

4. TPL Carrier Codes File

   On a monthly basis MMIS will send a TPL Carrier Code file to the Contractor.

5. FFS Wrap Services File

   On a daily basis MMIS will send claim data for assigned Enrollees who received services performed outside of the MCO's covered services on a Fee-For-Service basis.

Appendix K
Pharmacy Coverage for Dually Eligible Enrollees

Unless otherwise directed by EOHHS, for Dually Eligible Enrollees that EOHHS enrolls in the Contractor's Plan:

1. Ongoing Coverage for a One Time 72-Hour Supply of Drugs
The Contractor shall provide a one-time 72-hour supply of any drug that is a MCO Covered Service for Dually Eligible Enrollees, provided that such drug is not otherwise covered by the Dually Eligible Enrollee's Medicare Part D Plan.

2. Co-Payments
The Contractor shall ensure that no Dually Eligible Enrollee shall have out-of-pocket costs for drugs that are a MCO Covered Service for Dually Eligible Enrollees and covered by their Medicare Part D Plan that are higher than what they would have been responsible for under their MassHealth drug coverage.

3. MassHealth Covered Pharmacy Benefits
Notwithstanding anything to the contrary herein, the Contractor shall continue to provide the following MassHealth Covered Pharmacy Benefits to Dually Eligible Enrollees in accordance with the provisions of the Contract:

Class	**Therapy Class/GCN**
Prescription Vitamins/Minerals Excluding prenatals	C1F,C1H,C3B,C3C,C3M,C6A,C6B,C6D,C6H,C6K, C6L,C6M,C6Q,C6T,C6Z minus OTCs
OTC excluding insulin	OTC products minus C4G

APPENDIX L

MASSHEALTH FORM FOR CERTAIN FEDERALLY-REQUIRED DISCLOSURES

Federally Required Disclosures

Ownership and Control, Business Transactions and Criminal Convictions

(42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3)

Federal law requires fiscal agents, managed care entities (MCEs), and other MassHealth providers, including applicants and certain bidders seeking to provide MassHealth services, to disclose some or all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3. MassHealth requires the submission of tax identification numbers (TINs), for example, social security number (SSN) or employer identification number (EIN), for purposes necessary to properly administer the MassHealth program (See 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405 (c)(1).) Unless otherwise instructed by MassHealth, fiscal agents, MCEs, and other providers, must use this form when disclosing such information to MassHealth.

The following terms are defined in 42 CFR 438.2.

- Health Insuring Organization (HIO)
- Managed Care Organization (MCO)
- Prepaid Ambulatory Health Plan (PAHP)
- Prepaid Inpatient Health Plan (PIHP)
- Primary Care Case Manager (PCCM)

I. Disclosing Entities

All providers, disclosing entities, and others completing this form must complete Sections IV.A. and IV.F. Other information that must be disclosed and the timing of the disclosure varies depending on the identity of the disclosing entity as specified below.

A. Providers and PCCMs

(1) Disclosures of Ownership and Control (Section IV.B.) are due

(a) upon submission of a provider application;

(b) upon execution of the provider agreement with MassHealth;

(c) upon MassHealth's request during revalidation of enrollment; and

(d) within 35 days after any change in ownership of the entity required to disclose.

(2) Disclosures of Business Transactions (Section IV.C.) are due within 35 days of MassHealth's written request.

(3) Disclosures of Criminal Convictions (Section IV.D.) are due

(a) upon submission of a provider application;

(b) upon execution or renewal of the provider agreement with MassHealth; and

(c) upon MassHealth's written request.

(4) Disclosures of Relationships to Excluded, Penalized or Convicted Persons (Section IV.E.) are due

(a) upon execution of a provider agreement with MassHealth;

(b) upon renewal of the provider agreement with MassHealth; and

(c) upon MassHealth's written request.

B. Provider applicants

Provider applicants must provide Ownership and Control and Criminal Conviction Disclosures, and Disclosures of Relationships of Excluded, Penalized, or Convicted Persons (Section IV. B, D, and E), as detailed above, however, they are not required to disclose Business Transactions (Section IV.C).

C. Fiscal agents

Disclosures of Ownership and Control (Section IV.B.) are due

(1) upon submission of a proposal in accordance with the state procurement process;

(2) upon execution of a contract with MassHealth;

(3) upon renewal or extension of the contract with MassHealth; and

(4) within 35 days after any change in ownership.

D. MCEs (MCOs, PIHPs, PAHPs, and HIOs except PCCMs)

(1) Disclosures of Ownership and Control (Section IV.B.) are due

(a) upon submission of a proposal in accordance with the state procurement process;

(b) upon execution of a contract with MassHealth;

(c) upon renewal or extension of the contract with MassHealth; and

(d) within 35 days after any change in ownership.

(2) Disclosures of Business Transactions (Section IV.C.) are due within 35 days of MassHealth's written request.

(3) Disclosures of Criminal Convictions (Section IV.D.) are due

(a) upon submission of a provider application;

(b) upon execution or renewal of the provider agreement with MassHealth; and

(c) upon MassHealth's written request.

(4) Disclosures of Relationships to Excluded, Penalized, or Convicted Persons (Section IV.E.) are due

(a) upon execution of a contract with MassHealth;

(b) upon renewal of the contract with MassHealth; and

(c) upon MassHealth's written request.

Please attach an additional page or pages if necessary.

II. Definitions for Sections IV. B-D

Definitions for the terms that are used in this form are provided here for your convenience. The source of these definitions is 42 CFR § 455.101.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed Care Entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs, as defined by 42 CFR §455.101.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes (a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII); (b) any Medicare intermediary or carrier; and (c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that (a) has an ownership interest totaling five percent or more in a disclosing entity; (b) has an indirect ownership interest equal to five percent or more in a disclosing entity; (c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity; (d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity; (e) is an officer or director of a disclosing entity that is organized as a corporation; or (f) is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

III. Determination of Ownership or Control Percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. The source of these definitions is 42 CFR § 455.102.

A. Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation, which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

B. Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

IV. Disclosures

A. Identification Information

All applicants, bidders, disclosing entities, fiscal agents, and providers, including MCEs, must complete this section.

Name:_____

_____

_____

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

_____

Provider ID/service location (PID/SL) for existing MassHealth providers: _____

_____

_____

Contact person: _____

Title: _____

Phone no.: _____

B. Ownership and Control

All applicants, bidders, disclosing entities, fiscal agents, and providers, including MCEs, must complete this section, unless otherwise directed by MassHealth.

(1) List the name and address of any person (individual or legal entity) with an ownership or control interest in the entity providing these disclosures, or with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more. Provide the date of birth and SSN (for individuals identified), or other TIN (for legal entities identified), and complete the additional requested information. Attach a separate sheet if additional space is needed. If there is no person or entity in this category, please respond "None."

(a) Name: _____

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

SSN or TIN: _____

Date of birth (if an individual): _____

The individual or legal entity identified above has an ownership or control interest in which entity(ies):

- The entity providing these disclosures? ☐ Yes ☐ No
- A subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more? ☐ Yes ☐ No

► Name and address of the subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

_____

► SSN or TIN of the subcontractor:

_____

_____

(b) Name: _____

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

SSN or TIN: _____

Date of birth (if an individual): _____

The individual or legal entity identified above has an ownership or control interest in which entity(ies):

- The entity providing these disclosures? ☐ Yes ☐ No
- A subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more? ☐ Yes ☐ No

► Name and address of the subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.):

_____

_____

_____

► SSN or TIN of the subcontractor:

_____

_____

(2) Identify any individuals or legal entities named in question 1 as having an ownership or control interest, who are related to each other as spouse, parent, child, or sibling; and identify the particular relationship. If there are no such relationships, please respond "None."

_____

_____

(3) Identify any individuals or legal entities listed in question 1 as having an ownership or control interest, who also have an ownership or control interest in any other disclosing entity (or fiscal agent or MCE), and provide the name of each such other disclosing entity. If there are no individuals or legal entities with such interest, please respond "None." Attach a separate sheet if additional space is needed.

(a) Name: _____

Other entity name: _____

Other entity address: _____

(b) Name: _____

Other entity name: _____

Other entity address: _____

(4) Identify and provide the following information for each managing employee. If there are no managing employees, please respond "None." Attach a separate sheet if additional space is needed.

(a) Managing employee: _____

Address: _____

SSN: _____

Date of birth: _____

(b) Managing employee: _____

Address: _____

SSN: _____

Date of birth: _____

(c) Managing employee: _____

Address: _____

_____

_____

SSN: _____

Date of birth: _____

C. Business Transactions

Complete this section only if MassHealth directs you to do so. (Applicants and fiscal agents do not need to complete this section.)

(1) Identify the ownership of any subcontractor with whom the provider, including an MCE, has had business transactions totaling more than $25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent or more. If there are no such business transactions to report, please respond "None." Attach a separate sheet if additional space is needed.

(a) Subcontractor: _____

Address: _____

_____

SSN or TIN: _____

(i) Name of owner: _____

Address: _____

_____

(ii) Name of owner: _____

Address: _____

_____

(b) Subcontractor: _____

Address: _____

_____

SSN or TIN: _____

(i) Name of owner: _____

Address: _____

_____

(ii) Name of owner: _____

Address: _____

_____

(2) Identify any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five-year period before the date of this request. If there are no significant business transactions to report, please respond "None." Attach a separate sheet if additional space is needed.

_____

_____

_____

D. Criminal Convictions

Applicants, bidders, and providers, including MCEs, must complete this section, unless otherwise directed by MassHealth.

Provide the requested information in this section for any person who

(1) (a) has an ownership or control interest in the disclosing applicant, bidder, MCE or provider, or

(b) is an agent or managing employee of the disclosing applicant, bidder, MCE or provider; and

(2) has also been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs.

If there are no persons with such interest, please respond "None." Attach a separate sheet if more space is needed.

Person 1

Name: _____

Address: _____

Relationship: ☐ person with an ownership or control interest
☐ agent
☐ managing employee

Conviction Information:

Crime(s): _____

Date of conviction: _____

Person 2

Name: _____

Address: _____

Relationship: ☐ person with an ownership or control interest
☐ agent
☐ managing employee

Conviction Information:

Crime(s): _____

Date of conviction: _____

E. Relationships to Excluded, Penalized, or Convicted Persons in accordance with 42 CFR §1002.3

All bidders, applicants, providers, including MCEs, must complete this section, unless otherwise directed by MassHealth.

(1) For purposes of section E only, the following terms are as defined in 42 CFR §1001.1001:

Agent means any person who has express or implied authority to obligate or act on behalf of an entity.

Immediate family member means, a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)

Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Ownership interest means an interest in:

(a) The capital, the stock or the profits of the entity, or

(b) Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

(2) (a) Please identify, and provide the requested information in this section regarding any person who:

(i) has been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;

(ii) has had civil money penalties or assessments imposed under section 1128A of the Social Security Act; or

(iii) has been excluded from participation in Medicare or any of the state health care programs, **and**

(b) who also has one or more of the following relationships to the disclosing bidder, applicant, MCE, or other provider:

(i) has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the entity;

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity;

(iii) is an officer or director of the entity, if the entity is organized as a corporation;

(iv) is partner in the entity, if the entity is organized as a partnership;

(v) is an agent of the entity;

(vi) is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof; or

(vii) was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

If there are no persons with such interest, please respond "None." Attach a separate sheet if more space is needed.

Person 1

Name: _____

Address: _____

Relationship: _____
☐ Current ☐ Former

☐ Conviction Information:

Crime(s): _____

Date of conviction: _____

☐ Penalty or Assessment Information:

Reason(s): _____

Date penalty or assessment imposed: _____

Exclusion Information (Medicare):

Reason(s): _____

Date of exclusion: _____

☐ Exclusion Information (state health care program):

State(s): _____

Reason(s): _____

Date of exclusion: _____

Person 2

Name: _____

Address: _____

Relationship: _____
☐ Current ☐ Former

☐ Conviction Information:

Crime(s): _____

Date of conviction: _____

☐ Penalty or Assessment Information:

Reason(s): _____

Date penalty or assessment imposed: _____

Exclusion Information (Medicare):

Reason(s): _____

Date of exclusion: _____

☐ Exclusion Information (state health care program):

State(s): _____

Reason(s): _____

Date of exclusion: _____

F. Provider/Fiscal Agent/MCE/Applicant, Bidder Attestation, Signature, and Date

All providers, disclosing entities, fiscal agents, MCEs, applicants, and bidders must complete this section.

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under the pains and penalties of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's/disclosing entity's/fiscal agent's/MCE's/applicant's/bidder's signature (signature and date stamps, or the signature of anyone other than the provider/fiscal agent, applicant, bidder, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.):

Signature: _____

Date: _____

Printed name: _____

Title: _____

FEDERALLY REQUIRED DISCLOSURES

INDIVIDUAL PRACTITIONERS

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

Please ensure that all sections of this form are completed before submission.

Federal law requires that individual practitioners providing or seeking to provide services to MassHealth members disclose certain information to MassHealth. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3. MassHealth requires the submission of tax identification numbers (TINs), e.g., social security numbers (SSNs) or employer identification numbers (EINs), for purposes necessary to properly administer the MassHealth program (see 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405(c)(1)). Unless otherwise instructed by MassHealth, individual practitioners must use this form when disclosing such information to MassHealth.

SECTION 1: PRACTITIONER INFORMATION

Legal Name of Practitioner (Last, First, Middle Initial)

Date of Birth | National Provider Identifier Number (NPI) | SSN

Home Street Address

City | State | Zip –

Tel. # – – | Fax # – –

E-mail

Preferred Contact Name (if different than above)

Preferred Contact E-mail (if different than above)

Tel. # – –

SECTION 2: PRIMARY SERVICE LOCATION (PSL) INFORMATION

DBA Name (Primarily applies to individuals who are sole proprietors and NOT to entities separately completing PE-FRD)
NONE

Is PSL address same as home address in Section 1? Yes No. If yes, practitioner need not complete remainder of Section 2.

PSL Street Address (street address only; P.O. Boxes are not acceptable)

City | State | Zip –

Tel. # – – | Fax # – –

E-mail

SECTION 3: INDIVIDUALS AND ENTITIES RELATED TO PRACTITIONER

List any individual or entity with which the practitioner has one or more of the relationships described below, whether such relationship is defined by the practitioner's relationship to or interest in the other party, or by the other party's relationship to or interest in the practitioner (e.g., list entities in which the practitioner is a managing employee, AND managing employees of the practitioner). Although unusual, check "NONE" if none.

i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the other party;

ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the other party or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the other party;

iii. Is an officer or director of the other party, if the other party is organized as a corporation;

iv. Is partner in the other party, if the other party is organized as a partnership;

v. Is an agent of the other party;

vi. Is a managing employee–e.g., an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the other party or part thereof, or directly or indirectly conducts the day-to-day operations of the other party or part thereof; or

vii. Was formerly described in i. – vi. of this section, but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil money penalty, or imposition of an exclusion.

Agent means any person who has express or implied authority to obligate or act on behalf of another party (e.g., office manager, billing agent, group practice).

Immediate family member means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother-, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in another party (e.g., an individual has a 10 percent ownership interest in an entity if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue).

Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Ownership interest means an interest in

- the capital, the stock, or the profits of another party; or
- any mortgage, deed, trust, note, or other obligation secured in whole or in part by the property or assets of another party.

NONE (if NONE continue to Section 4)

Name of Individual (Last, First, Middle Initial) or Entity	Ownership/Controlling Interest	Managing Employee	Agent
NPI	% of Ownership (if applicable)		
Title, Function, or Relationship to Practitioner			
Address (Home Address if Individual; Business Address if Entity)			
City	State	Zip	–
SSN (if Individual)	Date of Birth	EIN (if Entity)	

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE THAN THREE INDIVIDUALS OR ENTITIES OR ADDITIONAL ADDRESSES.
(All business, corporate, and P.O. boxes must be listed.) NUMBER OF
Please attach each such copy to the signed form. Please refer to all attached pages when answering the disclosure questions in Section 4.

Name of Individual (Last, First, Middle Initial) or Entity | Ownership/Controlling Interest | Managing Employee | Agent

NPI | % of Ownership (if applicable)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City | State | Zip | –

SSN (if Individual) | Date of Birth | EIN (if Entity)

Name of Individual (Last, First, Middle Initial) or Entity | Ownership/Controlling Interest | Managing Employee | Agent

NPI | % of Ownership (if applicable)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City | State | Zip | –

SSN (if Individual) | Date of Birth | EIN (if Entity)

SECTION 4: DISCLOSURES

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

4A. DISCLOSURE INFORMATION

Respond to the following questions on behalf of the practitioner AND any individuals/entities identified in Section 3 (except for question 5, where your response may be limited to the practitioner). If you answer "yes" to any question, provide a detailed explanation in Section 4B, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number.

1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?
   Yes | No

2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?
   Yes | No

3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)? Yes | No

4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
   Yes | No

5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities? Yes | No

6. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in questions 1 – 5, above?
   Yes | No

4B. ADDITIONAL EXPLANATION

If you answered "yes" to any question in Section 4A, you must provide a detailed explanation below, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

SECTION 5: CERTIFICATION STATEMENT

PLEASE READ CAREFULLY AND SIGN

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Printed Legal Name of Practitioner | Signature | Date

Note: Signature or date stamps, electronically generated signatures or dates, or the signature of anyone other than the practitioner are not acceptable.

Appendix M
POPS Batch Interfaces

All Interfaces from, or to, a Managed Care Organization (MCO) and POPS have been defined as batch interfaces (as opposed to transactional).

The POPS Portal is the appropriate Channel for uploading Claim files and PBM and MCO 837 Medication Network Files. Additionally this portal is where MCO Control Reports, MCO Error spreadsheets, and MCO Rejected Claim files are available for pickup.

All Claim files will be submitted in the formats and on the schedule as provided by EOHHS which may be customized by EOHHS from time to time with prior written notice to MCOs.

Current Formats are as follows:

1. MCO Pharmacy Claims Level Interface-Version 1: 6-8-10 (NCPDP Post-Adjudication Standard Version 2.1. – History View) and MCO Pharmacy Claims Level Interface Change Control Doc Version 1.3. (Exhibit PHM-1)

2. MassHealth Custom Interface Guide - 837 Medication Claims - Paid Claims File Layout for Batch Interface to Pharmacy Systems for Federal Drug Rebate. (Exhibit PHM-2)

3. MCO Pharmacy Provider Network Identification Layout
   Any MCO drug claims and reversals submitted that are rejected by EOHHS due to an unknown pharmacy provider, the MCO is required to complete and submit the MCO Pharmacy Provider Network layout 3 days prior to the submission of the MCO Error Correction files. (Exhibit PHM-3)

4. MCO 837 Medication Provider Network Identification Layout
   Any MCO 837 Medication claims and/or adjusted or voided claims submitted that are rejected by EOHHS due to an unknown providers, the MCO is required to complete and submit the MCO 837 Medication Network layout 3 days prior to the submission of the MCO Error Correction files. (Exhibit PHM-7).

5. MassHealth Drug Rebate File Submission Report for MCO Pharmacy Claims
   This report documents file submission requirements and due dates for the inclusion of MCO Pharmacy claims in the Massachusetts Medicaid invoicing for federal drug rebate. (Exhibit PHM-4)

6. MassHealth Drug Rebate File Submission Reports for MCO 837 Medication Claims
   This report documents file submission requirements and due dates for the inclusion of MCO 837 Medication claims in the Massachusetts Medicaid invoicing for federal drug rebate. (Exhibit PHM-8).

Schedule for Interfaces:

The MCO claims files must be uploaded to the POPS secure portal **within 5 calendar days** following the close of the prior month.

Any MCO Retail Pharmacy drug claims and reversals submitted that are rejected by EOHHS must be corrected and resubmitted in the MCO Error Correction file **at least 1 day** prior to the next month's MCO drug claim file submission.

Any MCO 837 Medication claims and/or adjusted or voided claims submitted that are rejected by EOHHS must be corrected and resubmitted in the MCO Error Correction file **at least 1 day** prior to the next month's MCO drug claim file submission

Listed below is a short description of each of the interfaces from, or to, POPS and the MCOs. Note that the terms INBOUND and OUTBOUND are used to denote the flow of data relative to POPS. Inbound is data coming from an MCO to POPS, and outbound is data coming from POPS to an MCO.

A. Inbound Interfaces

1. MCO Claims Files to EOHHS

   On a monthly basis, the Contractor shall transmit the Inbound MCO Retail Pharmacy Claims Level file to the Distribution/ MASS PBM/ (MCO Name)/ ToMassHealth/ folder to the POPS portal **within 5 calendar days** following the close of the prior month.

   On a monthly basis, the Contractor shall transmit the Inbound MCO 837 Medication Claims File v.7 to the Distribution/ MASS PBM/ (MCO Name-837)/Institutional / ToMassHealth folder for 837I claims and or Distribution/MASS PBM/ (MCO Name-837)/Professional / ToMassHealth folder for 837P claims to the POPS portal **within 5 calendar days** following the close of the prior month.

   MCO Retail pharmacy claims and/or reversals submitted that are rejected by EOHHS must be corrected using the MCO Error Correction File format and transmitted to the Distribution/ MASS PBM/ (MCO Name)/ ToMassHealth/ **at least 1 day prior to** the next month's MCO drug claim file submission

   MCO 837 Medication claims and/or adjusted or voided claims submitted that are rejected by EOHHS must be corrected using the MCO Error Correction File format and transmitted to the Distribution/ MASS PBM/ (MCO Name-837)/Institutional / ToMassHealth folder for 837I claims and or Distribution/MASS PBM/ (MCO Name-837)/Professional / ToMassHealth folder for 837P claims on the POPS portal **at least 1 day prior to** the next month's MCO 837 Medication claim file submission

2. MCO Provider File or their contracted PBMs Network file to EOHHS

   Any MCO drug claims and/or reversals submitted that are rejected by EOHHS due to an unknown pharmacy provider must be corrected using the MCO Provider Network layout and transmit to the Distribution/ MASS PBM/ (MCO Name)/ ToMassHealth/ folder on the POPS portal **3 days prior** to the submission of the Error Correction files.

   Any MCO 837 Medication claims and/or adjusted or voided claims submitted that are rejected by EOHHS due to an unknown Billing, Rendering, Attending provider or Facility Identifier must

be corrected using the MCO Provider Network layout and transmit to Distribution/ MASS PBM/ (MCO Name-837)/Institutional / ToMassHealth folder for 837I claims and or Distribution/MASS PBM/ (MCO Name-837)/Professional / ToMassHealth folder for 837P claims on the POPS portal **3 days prior** to the submission of the Error Correction files.

B. Outbound Interfaces

Error Correction Files to MCO from EOHHS

Any MCO Retail drug claims and reversals submitted that are rejected by EOHHS will be available for pickup via the POPS portal for three calendar days after e-mail notification to the MCO submitter containing an MCO Control Report, MCO Error Spreadsheet, and MCO Rejected Claim file on the Distribution/ MASS PBM/ (MCO Name)/ FromMassHealth/ folder within the POPS portal.

Any MCO 837 Medication claims and/or adjusted or voided claims submitted that are rejected by EOHHS will be transmitted to the MCO in the Rejected Claims File on the Distribution/ MASS PBM/ (MCO Name-837)/Institutional / FromMassHealth folder for 837I claims and or Distribution/MASS PBM/ (MCO Name-837)/Professional / FromMassHealth folder for 837P claims.

Appendix N: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
List of Suspended or Excluded MassHealth Providers	http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html	All providers which have been suspended or excluded by MassHealth	At enrollment & revalidation and as needed for all provider types
NPI – National Provider Identifier Verify provider's NPI	https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do	NPI Number, First Name, Last Name may be entered to verify that the provider is on the NPI database	At enrollment & revalidation and as needed for all provider types
OIG – CMS Office of Inspector General Verify exclusions	http://exclusions.oig.hhs.gov	Last name and first name are entered to see if there are any findings under the provider's name	At enrollment, revalidation & monthly for all provider types
BORIM – Mass. Medical Board Validate licenses, suspensions and actions	http://profiles.ehs.state.ma.us/Profiles/Pages/FindAPhysician.aspx	You may search by Name, Specialty, License Number or ZIP Code to validate the license and verify if findings that would prevent them from practicing in MassHealth	At enrollment, revalidation & weekly for all provider types
DEA Number Verify DEA number	https://www.deanumber.com	Last name, State if the provider is found, verify that the provider's DEA number is current and without issue	At enrollment & revalidation for all providers with a DEA
MedFile Verify exclusions	This file is downloaded from the Tibco server. MCOs should go to their SFTP site shared with CSC to download these files.	Last name, first name are searched from the drop down option to ensure the provider's name is not listed and that there are no current findings against them.	At enrollment, revalidation & monthly for all provider types
PEC States Verify other state's exclusions	This file is downloaded from the Tibco server. MCOs should go to their SFTP site shared with CSC to download these files.	View by last name, first name, and state to view termination data from CMS	At enrollment, revalidation & monthly for all provider types
DIA – Debarment List Verify debarments	http://www.mass.gov/lwd/workers-compensation/investigations/swos-issued.html	View debarment information by company name, address, city, and state to assure a provider is not listed	At enrollment & revalidation for all provider types

Appendix N: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
Licenses Verify exclusions	http://license.reg.state.ma.us/public/licque.asp?color=blue or https://checkalicense.hhs.state.ma.us/mylicenseverification/Search.aspx?facility=N	Verify individuals' licenses by number / business info / personal info to verify the license is current and there are no findings against the ID	At enrollment & revalidation for all provider types when there is a hit on Sam, LEIE, MedFile, OIG
SAM – System for Award Management	https://sam.gov/portal/SAM/#1	Enter the provider's last name then first name to verify that the provider is not on the SAM website	At enrollment, revalidation & monthly for all provider types
Death Master File Verify a provider is not listed as deceased	Download file with a subscription	Enter the provider's name and/or social security number to verify that any applicant or Reval provider is not on the death file	At enrollment & revalidation for all provider types
PECOS Verify provider's Medicare enrollment information You must have a user ID to access PECOS	https://ampedc3.cms.gov/amserver/cdcservlet?realm=legacyedc3&goto=https%3A%2F%2Fpecosai.cms.hhs.gov%3A443%2Fpecosai%2Flogin.action&RequestID=10148&MajorVersion=1&MinorVersion=0&ProviderID=https%3A%2F%2Fpecosai.cms.hhs.gov%3A443%2Famagent&IssueInstant=2015-04-14T09%3A51%3A42Z	Enter the provider's information (name and SS #) to verify that they have a Medicare number that is active.	At enrollment & revalidation for all provider types
CORI Submit verify any criminal record the within the state of Massachusetts You must have a user ID to access CORI	https://icori.chs.state.ma.us/icori/ext/login/login.action?_p=jrSw8VW0a8WNvtHhCjMVj3RacRdmZmDDlpMkSxSL5Iw	The CORI Request Form is to be completed by the provider types 07 or 61 submitted as part of their application to the CSC. All of the information on the form is entered. Access to CORI is limited and must be processed by those with access.	At enrollment & revalidation for applicable providers
JCAHO (Joint Commission) Verify provider's accreditation/certification status	http://www.qualitycheck.org/consumer/searchQCR.aspx#	You may search a provider based on name, zip code or state. JCAHO is checked for hospital that are applying or being revalidated as is required for complete credentialing.	At enrollment, revalidation and monthly for hospitals

Appendix N: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
NBCOT (Nat'l Board for Certification in Occupational Therapy Validate licenses and suspensions and actions	https://my.nbcot.org/OnlineCredentialVerification/	The certification page requests either the certification number or last name, first name. The results are reviewed for whether the provider is Active and if there are any actions against them currently or in the past	At enrollment, revalidation and monthly for therapists
ASHA (American Speech-Language-Hearing Assn.) Validate licenses and suspensions and actions	http://www.asha.org/eweb/ashadynamicpage.aspx?webcode=ccchome	The ASHA certification page requires either the 8-digit ASHA account number or the provider's first and last name as well as their state. The provider must be licensed by the Board of Speech and Language Pathology as well as be accredited by ASHA.	At enrollment, revalidation & monthly for hearing instrument specialists
CHAP (Community Health Accreditation Program) Validate licenses and suspensions and actions	http://www.chapapps.org/search/	The CHAP website is used to find an accredited Community Health Provider. The home page may be searched by either the Agency Name or by State. The results display the Organization, City and State, Accreditation Dates, and Services.	At enrollment, revalidation & monthly for CHCs
American Board of Opticianry Certification Validate licenses and suspensions and actions	http://www.abo-ncle.org/ABO/Certification/Search_Certification_Database/ABO/PublicQueries/Certification_Database.aspx	The ABO certification database is searched by last name, first name, city, state and zip. The results will display the Certificate holder, Company, Certification, City, State, ZIP, Status, and Expiration date.	At enrollment, revalidation & monthly for opticians
National Examining Board of Ocularists Validate licenses and suspensions and actions	http://www.neboboard.org/nebostaprov.htm	This website displays the National Registry of Board Certified Ocularists. There is no way to search by individual name.	At enrollment, revalidation & monthly for Ocularists
State of New Hampshire Board Actions Validate licenses and suspensions and actions	http://www.nh.gov/medicine/aboutus/actions/index.htm	The provider's name and /or license number is listed on the home page and then searched. Results will indicate the provider's license, start date, end date, expiration date, specialty, and schooling. It will also show "Remarks" indicating "status" such as inactive or dead.	At enrollment, revalidation & weekly verifications

Appendix N: Credentialing Websites

Website or Database	Go to:	What is Checked	Frequency
State of Rhode Island Board Actions Validate licenses and suspensions and actions	http://www.health.ri.gov/lists/disciplinaryactions/	The disciplinary actions page has 3 options for search; License type, Find by Name, or Filter by Date. Results are reviewed for matches to any Massachusetts providers.	At enrollment, revalidation & weekly verifications
State of Connecticut Board Actions Validate licenses and suspensions and actions	http://www.ct.gov/dph/cwp/view.asp?a=4061&q=387280	The CT DPH displays a Regulatory Action Report that posts actions taken against providers by calendar year and quarter. There are 25 quarters posted which have to be searched individually.	At enrollment, revalidation & weekly verifications Usually updated quarterly
State of New York Board Actions Validate licenses and suspensions and actions	http://w3.health.state.ny.us/opmc/factions.nsf http://www.op.nysed.gov/opd/rasearch.htm	The NY BOH has a search page for Board Action regarding a particular Physician or Physician Assistant. The physician or PA may be entered with the last name; the license number may be searched; the license type may be searched; or the search may be done by entering the effective date of the disciplinary action.	At enrollment, revalidation & weekly verifications
State of Vermont Board Actions Validate licenses and suspensions and actions	http://healthvermont.gov/hc/med_board/actions.aspx	The Vermont DPH site has a page that is for Board Actions by Month. Yearly actions may be reviewed historically back to 2006 by month. There is no board action search by individual alone.	At enrollment, revalidation & weekly verifications
State of Maine Board Actions Validate licenses and suspensions and actions	http://www.maine.gov/md/discipline/adverse-licensing-actions.html	The State of Maine Board of Licensure in Medicine displays a page titled “Adverse Licensing Actions”. These actions are displayed by year with no search ability by individual alone.	Weekly verifications
MA Nursing Board Actions Validate licenses and suspensions and actions	https://checkalicense.hhs.state.ma.us/MyLicenseVerification/	The MA License Verification Site has search options for Profession, License Type, Name, License Number, and Status. For nursing searches the top three options for license status will be Suspension, Revocation and Probation.	Monthly verifications

Appendix O

MCO Performance Standards – Focused Areas

This Appendix summarizes the key performance areas identified by EOHHS. In accordance with the Contract, **Section 2.3.B.3**, 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. Additionally, key performance areas are subject to modification as directed by EOHHS and do not reflect a comprehensive list of Contract requirements under this Contract. EOHHS shall notify the Contractor of any updates to the form and formats of the reports or to the thresholds.

	Contract section	Metric	Contract Requirement	Reporting	Frequency
1	2.14.B Appendix R	Encounter data	98% complete	Encounter Data Submission (Appendix E)	Monthly
2	2.7.D.1 CM-12	Paid clean claims	Pay 90%/99% of all Clean Claims for MCO Covered Services from Providers within 30/60 days from the date the Contractor receives the Clean Claim;	Claims processing report	Monthly
3	2.9.B.1.b CM-10-I	Accessibility – PCP (adult and pediatric)	Primary Care: w/i 48 hours for urgent care w/i 10 days for non-urgent symptomatic care w/i 45 days for non-symptomatic care	Timeliness of Care	Monthly or Quarterly
4	2.10.H.1 CM-3	Report Member telephone statistics	At least 90% of calls answered within 30 seconds	Member telephone statistics	Monthly
5	2.15.G F-31	Medical Loss Ratio	Minimum of 85%	Medical Loss Ratio (MLR) Report	Monthly
6	2.6.D.10.a	ED utilization	Reporting Y1. Either: % of members with over 6 visits per year OR % from the NYU algorithm	TBD	Quarterly
7	2.6.D.10.c	Inpatient Medical Admissions	Reporting Y1: Number of inpatient medical admissions per 1,000 members	TBD	Monthly
8	2.6.D.10.c	Inpatient Behavioral Health Admissions	Reporting Y1: Number of inpatient BH admissions per 1,000 members	TBD	Monthly
9	2.12.A	Appeals	Reporting Y1: Number of appeals per 1,000 members	Appeals report	Monthly
10	2.12.A	Complaints/ Grievances	Reporting Y1: Number of grievances per 1,000 members	Grievance report	Monthly

APPENDIX P
MCO-Administered ACO Contract Specifications

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

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

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

A. General Care Delivery Requirements

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

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

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

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

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

B. Care Needs Screening and Appropriate Follow-Up

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

1. The Approved ACO Agreement shall obligate the MCO-Administered ACO to assist the Contractor in developing, implementing, and maintaining procedures for completing an initial Care Needs Screening for each Attributed Member, and in making best efforts to complete such screening within required timeframes, as specified in Section 2.5.B.1 of the Contract;

2. The Care Needs Screening shall meet all requirements in Section 2.5.B.2 of the Contract;

3. The Approved ACO Agreement shall obligate the MCO-Administered ACO to assist the Contractor to evaluate Attributed Members' needs through means other than the Care Needs Screenings as described in Section 2.5.B.3 of the Contract;

4. The Approved ACO Agreement shall obligate the MCO-Administered ACO to ensure that Attributed Members receive Medically Necessary and appropriate care and follow-up based on their identified needs as specified in Section 2.5.B.4 of the Contract.

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

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

1. The Approved ACO Agreement shall obligate the MCO-Administered ACO to perform care coordination for Attributed Members with identified LTSS- or BH-related needs and all Enrollees as specified in Section 2.5.C.1 of the Contract;

2. The Approved ACO Agreement shall obligate the MCO-Administered ACO to have a Transitional Care Management program. The MCO-Administered ACO shall develop, implement, and maintain protocols for Transitional Care Management with all of the MCO-Administered ACO's Affiliated Hospitals. Such protocols shall be as described in Section 2.5.C.2 of the Contract;

3. The Approved ACO Agreement shall obligate the MCO-Administered ACO to assist the Contractor to ensure that the Contractor's Clinical Advice and Support Line meets the requirements in Section 2.5.C.3 of the Contract.

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

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

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

D. Comprehensive Assessment and Member-Centered Care Planning

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

E. Care Management

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

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

2. The Approved ACO Agreement shall obligate the MCO-Administered ACO to provide each identified Attributed Member with Care Management as set forth in Section 2.5.E.2 of the Contract.

Section 1.2 Certain Member Protections

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

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

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

1. Not impose additional requirements for referrals to providers who are not Affiliated Providers;
2. Not impede Attributed Members' access to or freedom of choice of providers;
3. Not reduce or impede access to Medically Necessary services; and
4. Ensure that Attributed Members may obtain emergency services from any provider, regardless of its affiliation with the MCO-Administered ACO, including but not limited to receiving services from ESP or MCI providers;

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

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

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

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

1. Contact information for EOHHS' Ombudsman;
2. A method for submitting inquiries, providing feedback, and initiating Grievances, which shall include but may not be limited to Grievances related to the MCO-Administered ACO, including for

Attributed Members who do not have access to email;

3. The identity, contact information, addresses, operating hours, qualifications, and availability of the MCO-Administered ACO's Affiliated Providers;

4. How Attributed Members may access oral interpretation services free-of-charge in any non-English language spoken by Attributed Members;

5. How Attributed Members may access written materials in Prevalent Languages and Alternative Formats;

6. Additional information as specified by EOHHS;

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

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

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

J. Facilitate Attributed Members' immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week;

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

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

A. Contractor and EOHHS involvement in TCOC calculation

1. EOHHS will calculate and provide the Contractor with values related to the TCOC calculation for each of the Contractor's MCO-Administered ACOs. The Contractor shall, for all calculations described in this Section 1.3 of Appendix P, use such values or other amounts calculated and provided to the Contractor by EOHHS.
2. The Contractor shall provide EOHHS with any requested information or assistance in calculating such values.
3. Values related to the TCOC calculation shall include but may not be limited to:
    a. The MCO-Administered ACO's TCOC Benchmark;
    b. The MCO-Administered ACO's TCOC Performance;
    c. The MCO-Administered ACO's Quality Score;
    d. The MCO-Administered ACO's Shared Savings or Share Losses payment, as modified by the MCO-Administered ACO's Quality Score; and
    e. Other values as specified by EOHHS;

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

1. If the difference when the MCO-Administered ACO's TCOC Performance is subtracted from the MCO-Administered ACO's TCOC Benchmark is equal to an amount greater than zero (0), such difference shall be the MCO-Administered ACO's Savings. If such difference is equal to an amount less than zero (0), such difference shall be the MCO-Administered ACO's Losses. If such difference equals zero (0) and the MCO-Administered ACO's TCOC Performance and TCOC Benchmark are equal to each other, the MCO-Administered ACO shall have neither Savings nor Losses for the Performance Year;
2. If the MCO-Administered ACO has Savings, the Contractor shall

pay the MCO-Administered ACO a Shared Savings payment based on the MCO-Administered ACO's Risk Track, as described in Section 1.3.C of this Appendix P;

3. If the MCO-Administered ACO has Losses, the MCO-Administered ACO shall pay the Contractor Shared Losses based on the MCO-Administered ACO's Risk Track, as described in Section 1.3.C of this Appendix P; and

4. If the MCO-Administered ACO has neither Savings nor Losses for the Performance Year, the MCO-Administered ACO shall have neither a Shared Savings payment nor a Shared Losses payment;

C. Risk Tracks

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

a. Risk Track 1 – Limited Accountability;

b. Risk Track 2 – Moderate Accountability; and

c. Risk Track 3 – Increased Accountability;

2. The Contractor shall apply Risk Tracks as follows:

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

1) The minimum savings and losses rate shall be equal to 2% of the TCOC Benchmark. If the MCO-Administered ACO's Savings or the absolute value of the MCO-Administered ACO's Losses are less than 2% of the TCOC Benchmark, there shall be no Shared Savings or Shared Losses payment;

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

cap, the MCO-Administered ACO's Shared Losses payment shall be calculated as if the absolute value of the MCO-Administered ACO's Losses were equal to the cap, and the MCO-Administered ACO shall make no additional Shared Losses payment for any Losses beyond the cap;

b. Risk Track 1 – Limited Accountability

If the MCO-Administered ACO's Risk Track as identified to the Contractor by EOHHS is Risk Track 1 – Limited Accountability, the MCO-Administered ACO's Shared Savings payment or Shared Losses payment, prior to modifying for the MCO-Administered ACO's Quality Score as described below, shall be as follows:

1) If the MCO-Administered ACO has Savings less than or equal to 3% of the TCOC Benchmark:

   a) In Performance Year 1, Shared Savings shall be twenty percent (20%) of Savings;

   b) In Performance Year 2, Shared Savings shall be twenty-five percent (25%) of Savings;

   c) In Performance Years 3-5, Shared Savings shall be thirty percent (30%) of Savings;

2) If the MCO-Administered ACO has Savings greater than 3% of the TCOC Benchmark, the MCO-Administered ACO's additional Shared Savings payment for the amount of Savings above 3% of the TCOC Benchmark shall be equal to:

   a) In Performance Year 1, additional Shared Savings shall be ten percent (10%) of such additional Savings;

   b) In Performance Year 2, additional Shared Savings shall be twelve and one half percent (12.5%) of such additional Savings; and

   c) In Performance Years 3-5, additional Shared Savings shall be fifteen percent (15%) of such additional Savings;

3) If the MCO-Administered ACO has Losses with absolute value less than or equal to 3% of the

TCOC Benchmark:

a) In Performance Years 1-3, Shared Losses shall be twenty percent (20%) of Losses; and

b) In Performance Years 4-5, Shared Losses shall be thirty percent (30%) of Losses;

4) If the MCO-Administered ACO has Losses with absolute value greater than 3% of the TCOC Benchmark, the MCO-Administered ACO's additional Shared Losses payment for the amount of Losses beyond 3% of the TCOC Benchmark shall be equal to:

a) In Performance Years 1-3, additional Shared Losses shall be ten percent (10%) of such additional Losses; and

b) In Performance Years 4-5, additional Shared Losses shall be fifteen percent (15%) of such additional Losses;

c. Risk Track 2 – Moderate Accountability

If the MCO-Administered ACO's Risk Track as identified to the Contractor by EOHHS is Risk Track 2 – Full Accountability, the MCO-Administered ACO Shared Savings payment or Shared Losses payment, prior to modifying for the MCO-Administered ACO Quality Score as described below, shall be as follows:

1) If the MCO-Administered ACO has Savings less than or equal to 3% of the TCOC Benchmark:

a) In Performance Year 1, Shared Savings shall be thirty percent (30%) of Savings;

b) In Performance Year 2, Shared Savings shall be forty percent (40%) of Savings;

c) In Performance Years 3-5, Shared Savings shall be fifty percent (50%) of Savings;

2) If the MCO-Administered ACO has Savings greater than 3% of the TCOC Benchmark, the MCO-Administered ACO's additional Shared Savings

payment for the amount of Savings above 3% of the TCOC Benchmark shall be equal to:

a) In Performance Year 1, additional Shared Savings shall be fifteen percent (15%) of such additional Savings;

b) In Performance Year 2, additional Shared Savings shall be twenty percent (20%) of such additional Savings;

c) In Performance Years 3-5, additional Shared Savings shall be twenty-five percent (25%) of such additional Savings;

3) If the MCO-Administered ACO has Losses with absolute value less than or equal to 3% of the TCOC Benchmark:

a) In Performance Years 1-3, Shared Losses shall be thirty percent (30%) of Losses; and

b) In Performance Years 4-5, Shared Losses shall be fifty percent (50%) of Losses;

4) If the MCO-Administered ACO has Losses with absolute value greater than 3% of the TCOC Benchmark, the MCO-Administered ACO's additional Shared Losses payment for the amount of Losses beyond 3% of the TCOC Benchmark shall be equal to:

a) In Performance Years 1-3, additional Shared Losses shall be fifteen percent (15%) of such additional Losses; and

b) In Performance Years 4-5, additional Shared Losses shall be twenty-five percent (25%) of such additional Losses;

d. Risk Track 3 – Increased Accountability

If the MCO-Administered ACO's Risk Track as identified to the Contractor by EOHHS is Risk Track 3 – Increased Accountability, the MCO-Administered ACO's Shared Savings payment or Shared Losses payment, prior to modifying for the MCO-Administered ACO's Quality Score as described below, shall be as follows:

1) If the MCO-Administered ACO has Savings less than or equal to 3% of the TCOC Benchmark:

   a) In Performance Year 1, Shared Savings shall be fifty percent (50%) of Savings;

   b) In Performance Year 2, Shared Savings shall be sixty percent (60%) of Savings; and

   c) In Performance Years 3-5, Shared Savings shall be seventy percent (70%) of Savings;

2) If the MCO-Administered ACO's has Savings greater than 3% of the TCOC Benchmark, the MCO-Administered ACO's additional Shared Savings payment for the amount of Savings above 3% of the TCOC Benchmark shall be equal to:

   a) In Performance Year 1, additional Shared Savings shall be twenty-five percent (25%) of such additional Savings;

   b) In Performance Year 2, additional Shared Savings shall be thirty percent (30%) of such additional Savings;

   c) In Performance Years 3-5, additional Shared Savings shall be thirty-five percent (35%) of such additional Savings;

3) If the MCO-Administered ACO has Losses with absolute value less than or equal to 3% of the TCOC Benchmark:

   a) In Performance Years 1-3, Shared Losses shall be forty percent (40%) of Losses; and

   b) In Performance Years 4-5, Shared Losses shall be seventy percent (70%) of Losses;

4) If the MCO-Administered ACO has Losses with absolute value greater than 3% of the TCOC Benchmark, the MCO-Administered ACO's additional Shared Losses payment for the amount of Losses beyond 3% of the TCOC Benchmark shall be equal to:

   a) In Performance Years 1-3, additional Shared

Losses shall be twenty percent (20%) of such additional Losses; and

b) In Performance Years 4-5, additional Shared Losses shall be thirty-five percent (35%) of such additional Losses;

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

D. Quality modifier and payment

Prior to payment, the Contractor's Shared Savings or Shared Losses payment shall be adjusted based on the MCO-Administered ACO's Quality Score, and the Contractor or MCO-Administered ACO shall pay the resulting adjusted amount, as follows:

1. The MCO-Administered ACO's Quality Score shall be a number between zero (0) and one (1) as determined by EOHHS;
2. If the MCO-Administered ACO has Shared Savings as calculated above, the MCO-Administered ACO's amount of such Shared Savings shall be multiplied by the MCO-Administered ACO's Quality Score. The resulting amount shall be the amount of the MCO-Administered ACO's Shared Savings payment for the Performance Year, and the Contractor shall pay Contractor such resulting amount;
3. If the MCO-Administered ACO has Shared Losses, eighty percent (80%) of such Shared Losses shall be unmodified by the MCO-Administered ACO's Quality Score. The remaining twenty percent (20%) of the MCO-Administered ACO's Shared Losses payment shall be multiplied by an amount equal to one (1) minus the MCO-Administered ACO's Quality Score. Such product, plus the unmodified eighty percent (80%) of the MCO-Administered ACO's initial Shared Losses, shall be the amount of the MCO-Administered ACO' Shared Losses payment for the Performance Year, and the MCO-Administered ACO shall pay the Contractor such resulting amount;
4. The Contractor shall pay the MCO-Administered ACO the Shared Savings payment, as adjusted for the MCO-Administered ACO's Quality Score in this Section, or notify MCO-Administered ACO of the MCO-Administered ACO's Shared Losses payment for each Performance Year no later than one calendar year from the end of

the Performance Year; and

5. The MCO-Administered ACO shall pay the Contractor any Shared Losses payment, as adjusted for Contractor's Quality Score as set forth in this Section, within thirty (30) days of receiving such notification from the Contracting MCO of the amount of the Contractor's Shared Losses payment;

E. TCOC Benchmark and TCOC Performance calculations

1. The MCO-Administered ACO's TCOC for a given period shall be calculated as follows and as further specified by EOHHS, and using values calculated and provided to the Contractor by EOHHS as described in Section 1.3.A of this Appendix P above:

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

b. TCOC shall include all paid claims and encounters with dates of service during such period, where the Member receiving the service was Contractor's Attributed Member on the date of service, except for services that are not MCO Covered Services as set forth in Appendix C of the Contract on the date of service.

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

d. TCOC shall exclude certain amounts as further specified by EOHHS to account for Attributed Members with very high annual expenditures. EOHHS shall identify such Attributed Members and reduce their contribution to the MCO-Administered ACO's TCOC by excluding and adjusting certain amounts paid; and

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

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

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

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

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

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

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

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

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

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

      2) Base rates for each EOHHS rating category shall be calculated based on the costs of care for all ACO-

Eligible Members in each such rating category during a baseline period, as further specified by EOHHS, and using similar adjustments and exclusions as described above for TCOC calculations;

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

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

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

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

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

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

adjustments such as:

1) Additional program changes not initially captured;

2) Modifications to trend based on unforeseen events;

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

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

APPENDIX Q: Enrolling Providers Required Data Elements

A. Required Data Elements For Enrollment

MassHealth Requirement	Submitted by MCO
File submitter ID	MassHealth PID/SL of MCO
(describe t_pr_identifier)	
ALT_ID_PROVIDER	Enrolling Providers' NPI
(describe t_pr_type)	
CDE_PROV_TYPE	Tell us provider type –see Appendix A1
(describe t_pr_tax_id)	
NUM_TAX_ID	SSN or FEIN #
IND_TAX_ID_TYPE	Must tell us type (S= SSN or F= FEIN)
(describe t_pr_nam)	
NAME	First, Last, Middle or Business Name
IND_NAME_TYPE	Tell us B=Business Name or P=Personal
(describe t_pr_adr)	Doing Business As Address & Phone #
ADR_MAIL_STRT1	
ADR_MAIL_STRT2	
ADR_MAIL_CITY	
ADR_MAIL_STATE	
ADR_MAIL_ZIP	
ADR_MAIL_ZIP_4	Optional
NUM_PHONE	
NUM_PHO_EXT	Optional
(describe t_pr_dea)	Optional: DEA when applicable
NUM_DEA	
DTE_EFFECTIVE	
DTE_EXPIRATION	
(describe t_pr_svc cert)	Optional: License or other certifications see Appendix A2 for type
CDE_CERT_TYPE	
NUM_PROV_CERT	
DTE_EFFECTIVE	
DTE_END	
(T_PR_MCARE_BILL)	
NUM_MEDICARE	Medicare number assigned by the government to the provider
CDE_MCARE_TYPE	Medicare type, valid values are **A** (Part A) and **B** (Part B).
DTE_EFFECTIVE	The first date in which the Medicare number became effective.
SAK_CARRIER	CMS Intermediary or Medicare Carrier code up to 9 numbers

DTE_END	The last date in which the Medicare number will expire.
(describe T_IRS_W9_INFO)	
NAME	This is the name the W9 form would be addressed to.
ADR_MAIL_STRT1	This is the street address where the provider would receive the W9 form
ADR_MAIL_STRT2	optional
ADR_MAIL_CITY	This is the city where the provider would receive the W9 form
ADR_MAIL_STATE	This is the state where the provider would receive the W9 form
ADR_MAIL_ZIP	This is the zip code where the provider would receive the W9 form.
ADR_MAIL_ZIP_4	optional
DTE_EFFECTIVE	The first date the W9 information for this provider becomes effective.
NUM_PHONE	The phone number of the legal entity in format: Area Code + Prefix +Suffix
NUM_PHONE_EXT	optional
describe T_PR_SVC_LOC	
IND_PCC	If the provider is a Primary Care Provider within the MCO enter Y otherwise enter N
(describe T_PR_AFF_PR_LOC_XREF)	This identifies the relationship to the MCO;
SAK_AFF_PROV	Enter the submitter ID on file i.e. MCO PID
CDE_AFF_SVC-LOC	Enter submitter ID on file i.e. MCO SL
DTE_EFFECTIVE	Date file is received
DTE_END	12/31/2299
CDE_AFF_TYPE	MP
describe T_PR_PROV	
IND_MCO	If the provider is “in Network” enter Y, otherwise enter N

A-1 Provider Types

CDE_PROV_TYPE	DSC_PROV_TYPE
O1	PHYSICIAN
O2	OPTOMETRIST
O3	OPTICIAN
O4	OCULARIST
O5	PSYCHOLOGIST
O6	PODIATRIST
O7	THERAPIST
O8	NURSE MIDWIFE
O9	NURSING FACILITY
10	DENTIST
11	DENTAL CLINIC
12	DENTAL SCHOOL CLINIC UNDERGRADUATE
13	DENTAL SCHOOL CLINIC GRADUATE
14	PUBLIC HEALTH DENTAL HYGIENIST
15	OPTOMETRY SCHOOL
16	CHIROPRACTOR
17	NURSE PRACTITIONER
18	MANAGED CARE RMC CONTRACTOR
19	ICO PROVIDERS
20	COMMUNITY HEALTH CENTER (CHC)
21	FAMILY PLANNING AGENCY
22	ABORTION/STERILIZATION CLINIC
23	SPEECH AND HEARING CENTER
24	REHABILITATION CENTER
25	RENAL DIALYSIS CLINIC
26	MENTAL HEALTH CENTER
27	CHAPTER 766
28	SUBSTANCE ABUSE PROGRAM
29	EARLY INTERVENTION
30	HEALTH MAINTENANCE ORGANIZATION
31	VOLUME PURCHASER
32	DENTAL PLAN (Obsolete)
33	CASE MANAGEMENT
34	COMMONHEALTH *** OBSOLETE ***
35	STATE AGENCY SERVICES
36	DPH TRANSPORTATION (& DPH WAIVER)
37	PACE
38	PREFERRED PHYSICIAN PROGRAM *** OBSOLETE ***
39	PHYSICIAN ASSISTANT
40	PHARMACY
41	DURABLE MEDICAL EQUIPMENT
42	OXYGEN AND RESPIRATORY THERAPY EQUIP
43	PROSTHETICS

44	HEARING INSTRUMENT SPECIALIST
45	INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)
46	CERTIFIED INDEPENDENT LABORATORY
47	ORTHOTICS
48	PERS *** OBSOLETE ***
49	TRANSPORTATION
50	AUDIOLOGIST
51	CERTIFIED REGISTERED NURSE ANESTHETISTS
52	ICR-MR COMMUNITY *** OBSOLETE ***
53	ICF-MR STATE SCHOOL
54	APPLIED BEHAVIORAL ANALYSIS WITH TPL
55	REST HOME
56	MFP DEMONSTRATION
57	CLINICAL NURSE SPECIALIST (CNS)
58	FISCAL INTERMEDIARY SERVICES
59	PERSONAL CARE MANAGEMENT AGENCY
60	HOME HEALTH AGENCY
61	INDEPENDENT NURSE
62	ADULT FOSTER CARE / GROUP ADULT FOSTER CARE
63	ADULT DAY HEALTH
64	DAY HABILITATION
65	PSYCHIATRIC DAY TREATMENT
66	INDEPENDENT LIVING
67	RESPITE CARE *** OBSOLETE ***
68	HOME CARE CORPORATION
69	HOSPICE CARE
70	ACUTE INPATIENT HOSPITAL
71	CHRONIC INPATIENT HOSPITAL
72	PSYCHIATRIC INPATIENT HOSPITAL *** OBSOLETE ***
73	PSYCHIATRIC INPATIENT HOSPITAL (ALL AGES)
74	SEMI ACUTE INPATIENT HOSPITAL
75	SEMI ACUTE OUTPATIENT HOSPITAL
76	INTENSIVE RESIDENTIAL TREATMENT PROGRAM (IRTP)
77	SENIOR CARE OPTIONS (SCO)
78	PSYCHIATRIC NURSE MENTAL HEALTH SPECIALISTS
79	DMEPOS
80	ACUTE OUTPATIENT HOSPITAL
81	HOSPITAL LICENSED HEALTH CENTER (HLHC)
82	CHRONIC OUTPATIENT HOSPITAL
83	PSYCHIATRIC OUTPATIENT HOSPITAL
84	AMBULATORY SURGERY CENTER
85	BIRTHING CENTER
86	QMB ONLY PROVIDERS
87	RADIATION ONCOLOGY TREATMENT CENTERS
88	SYSTEM DEFAULT LEGACY (OBSOLETE)
89	SCHOOL-BASED MEDICAID
90	PHARMACIST

91	INDIAN HEALTH SERVICES
92	CLINICAL SOCIAL WORKER
93	THIRD PARTY ADMINISTRATOR
94	ACCOUNTABLE CARE PROVIDER ORG
95	COMPLEX CARE MANAGEMENT
96	LIMITED SERVICES CLINICS
97	GROUP PRACTICE ORGANIZATION
98	SPECIAL PROGRAMS
99	RELATIONSHIP ENTITY

A-2 Certification Types

CDE_CERT_TYPE	DSC_CERT_TYPE
OO	Unknown
O1	MA BOARD OF REGISTRATION IN MEDICINE
O2	MASS. BOARD OF REGISTRATION IN DENTISTRY
O3	MASS. BOARD OF REGISTRATION OF OPTOMETRISTS
O4	MASS. BOARD OF REGISTRATION IN PODIATRY
O5	MASS. BOARD OF REGISTRATION IN NURSING
O6	AMERICAN SPEECH-LANGUAGE HEARING ASSOC. (ASHA)
O7	BOARD OF REG OF ALLIED HEALTH PROFESSIONALS
O8	MASS. BOARD OF REGISTRATION OF PSYCHOLOGISTS
O9	MASS. BOARD OF REGISTRATION IN PHARMACY
10	MA BOARD OF REGISTRATION OF DISPENSING OPTICIANS
11	MASS. DEPARTMENT OF PUBLIC HEALTH LICENSURE
12	MA DEP PUB HLTH/MEDCRE CT & DEP PUB WEL/MEDCD CT
13	AMERICAN OCCUPATIONAL THERAPY ASSOC. REGISTRATION
14	AMERICAN SOCIETY OF OCULARISTS
15	MASS. DEPT OF PUBLIC WELFARE: MEDICAID CERT.
16	NATIONAL BOARD FOR RESPIRATORY CARE
17	AMERICAN BOARD FOR CERT IN ORTHOTICS & PROSTHETICS
18	MEDICARE CERTIFICATION
19	MA DEPT OF PUB HLTH & DEPT OF PUB WEL/MEDCD CERT
20	MASS. CITY OR TOWN AUTHORIZATION
21	OUT-OF-STATE LICENSE/CERT./REGISTRATION
22	JCAHO ACCREDITATION & MEDICARE CERT.
23	OPH LICENSE & CARF ACCREDITATION
24	DPH LICENSE & ASHA CERT.
25	DPH LICENSE & MEDICARE CERT.
26	DPH-LICENSE & MEDCD CERT.
27	MASS. PHYSICIAN LICENSE & MASS. MEDCD CERT.
28	GOVERNMENT OPERATED & MEDICARE CERT.
29	GOVERNMENT OPERATED
30	O-O-STATE LIC, MEDCRE CERT & O-O-STATE MEDCD CERT
31	OUT-OF-STATE LICENSE/CERT/REGISTRATION & CARF CERT
32	OUT-OF-STATE LIC/CERT/REGISTRATION & ASHA CERT
33	O-O-STATE LIC/CERT/REGISTR & O-O-STATE MEDCRE CERT
34	O-O-STATE LIC/CERT/REGISTR & O-O-STATE MEDCD CERT
35	OUT-OF-STATE MEDCD CERT.
36	OUT-OF-STATE MEDCD CERT. & MEDICARE CERT.
37	O-O-S LIC/CT/REG & O-O-S MEDCD CT & MA MEDCD CERT
38	LIC/CERT/REGISTR ONLY APPLICABLE TO SPECIALTY
39	OUT-OF-STATE LICENSE & MASS. MEDCD CERT.
40	NATIONAL CERT. & OUT-OF-STATE MEDICAL CERT.
41	O-O-ST GVT OPD & MEDCRE CERT & O-O-ST MEDCD CERT
42	NOT APPLICABLE

43	OTHER
44	MA DIV OF LICENSE INS; LICENSURE AND MA MED CERT
45	FED QUAL HMP MA DIV OF LIC INS; LIC & MA MED CERT
46	MASS BOARD OF REGISTRATION OF CHIROPRACTORS
47	BOARD OF REG OF ALLIED MENTAL HHS PROFESSIONALS
48	BOARD OF REGISTRATION OF SOCIAL WORKERS
49	BOARD OF REGISTRATION OF SPEECH AND AUDIOLOGY
50	BOARD OF REG OF HEARING INSTRUMENT SPECIALISTS
51	BOARD OF REGISRTATION OF DIETICIANS AND NUTRITION
52	DPH-OFFICE OF EMERGENCY MEDICAL SERVICES
53	DEPARTMENT OF MENTAL HEALTH
54	COMMUNITY HEALTH ACCREDIATION PROGRAM
55	HEALTHCARE QUALITY ASSOCIATION ON ACCREDIATION
56	NATIONAL BOARD OF ACCRED FOR ORTHOTIC SUPPLIERS
57	BOARD OF CERTIFICATION IN PEDORTHICS
58	ACCREDIATION COMMISSION FOR HEALTHCARE, INC
59	NATIONAL ASSOCIATION OF BOARDS OF PHARMACY
60	COMMISSION ON ACCREDIATION OF REHAB FACILITIES
61	THE COMPLIANCE TEAM INC
62	ACDD
63	BOARD OF REG OF NURSING HOME ADMINSTRATORS
64	NATIONAL BOARD FOR CERT IN HEARING INST SCIENCES
65	NATIONAL ADULT FAMILY CARE ORGANIZATION
66	BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS

B. Update Specifications

MassHealth Requirement	Submitted by MCO
File submitter ID	MassHealth PID/SL of MCO
describe t_pr_identifier/ID_PROVIDER	Provider' PID/SL (**Required**)

Include as applicable when changed

NAME	First, Last, Middle or Business Name
IND_NAME_TYPE	Tell us B=Business Name or P=Personal
ADR_MAIL_STRT1	Doing Business As Address & Phone #
ADR_MAIL_STRT2	
ADR_MAIL_CITY	
ADR_MAIL_STATE	
ADR_MAIL_ZIP	
ADR_MAIL_ZIP_4	
NUM_PHONE	
NUM_PHO_EXT	
NUM_TAX_ID	SSN or FEIN #
IND_TAX_ID_TYPE	Must tell us type (S= SSN or F= FEIN)
CDE_ENROLL_STATUS	If the provider has left the MCO, enter 60 *(VOLUNTARY SUSPENSION PROVIDER WITHDRAWAL);* if the provider is deceased, enter 71 (*VOL SUSPENSION PROVIDER DECEASED)*

Appendix R: Service Areas

MassHealth ACO Partnership Plan Service Area- City/Town Crosswalk

Service Area	City, Town
BOSTON - PRIMARY	Allston
	Babson Park
	Boston
	Brighton
	Brookline
	Brookline Village
	Charlestown
	Chestnut Hill
	Dorchester
	Hyde Park
	Jamaica Plain
	Mattapan
	Readville
	Roslindale
	Roxbury
	Waban
	Waverley
	West Roxbury
REVERE	East Boston
	Chelsea
	Revere
	Winthrop
SOMERVILLE	Arlington
	Arlington Heights
	Cambridge
	Somerville
QUINCY	Accord
	Braintree
	Cohasset
	Dedham
	Greenbush
	Hingham
	Hull
	Milton
	Milton Village
	Minot
	North Scituate
	Norwell
	Norwood
	Quincy
	Randolph
	Scituate
	Westwood
	Weymouth

Service Area	City, Town
BEVERLY	Beverly

Appendix R: Service Areas

	Hamilton
	Manchester By The Sea
	Prides Crossing
	South Hamilton
	Topsfield
	Wenham
GLOUCESTER	Essex
	Gloucester
	Ipswich
	Rockport
HAVERHILL	Amesbury
	Boxford
	Byfield
	Georgetown
	Groveland
	Haverhill
	Merrimac
	Newbury
	Newburyport
	Rowley
	Salisbury
	West Boxford
	West Newbury
LAWRENCE	Andover
	Lawrence
	Methuen
	North Andover
LOWELL	Acton
	Billerica
	Carlisle
	Chelmsford
	Concord
	Dracut
	Dunstable
	Lincoln
	Littleton
	Lowell
	North Billerica
	North Chelmsford
	Nutting Lake
	Pinehurst
	Tewksbury
	Tyngsboro
	Vill. of Nagog Woods
	Westford
LYNN	Lynn
	Lynnfield
	Nahant
	Saugus
	Swampscott
MALDEN	Everett

Appendix R: Service Areas

	Malden
	Medford
	Melrose
	Wakefield
	West Medford
SALEM	Danvers
	Hathorne
	Marblehead
	Middleton
	Peabody
	Salem
WOBURN	Bedford
	Burlington
	Lexington
	North Reading
	Reading
	Stoneham
	Wilmington
	Winchester
	Woburn

Service Area	City, Town
ATTLEBORO	Attleboro
	Chartley
	East Mansfield
	Foxboro
	Mansfield
	North Attleboro
	Norton
	Plainville
	Sheldonville
	Wrentham
BARNSTABLE	Barnstable
	Centerville
	Cotuit
	Cummaquid
	Hyannis
	Hyannis Port
	Marstons Mills
	Osterville
	South Yarmouth
	West Barnstable
	West Hyannisport
	West Yarmouth
	Yarmouth
	Yarmouth Port
BROCKTON	Abington
	Avon
	Bridgewater
	Brockton

Appendix R: Service Areas

	Canton
	East Bridgewater
	Easton
	Elmwood
	Holbrook
	North Easton
	Rockland
	Sharon
	South Easton
	Stoughton
	West Bridgewater
	Whitman
FALL RIVER	Assonet
	East Freetown
	Fall River
	Freetown
	Somerset
	Swansea
	Westport
	Westport Point
FALMOUTH	Bourne
	Buzzards Bay
	Cataumet
	Cuttyhunk
	East Falmouth
	East Sandwich
	Falmouth
	Forestdale
	Gosnold
	Mashpee
	Monument Beach
	North Falmouth
	Pocasset
	Sagamore
	Sagamore Beach
	Sandwich
	West Falmouth
	Woods Hole
NANTUCKET	Nantucket
	Siasconset
NEW BEDFORD	Acushnet
	Dartmouth
	Fairhaven
	Marion
	Mattapoisett
	New Bedford
	North Dartmouth
	Rochester
	South Dartmouth
OAK BLUFFS	Chilmark
	Edgartown

Appendix R: Service Areas

	Gay Head
	Menemsha
	Oak Bluffs
	Tisbury
	Vineyard Haven
	West Tisbury
ORLEANS	Brewster
	Chatham
	Dennis
	Dennis Port
	East Dennis
	Eastham
	East Orleans
	Harwich
	Harwich Port
	North Chatham
	North Eastham
	North Truro
	Orleans
	Provincetown
	South Chatham
	South Dennis
	South Harwich
	South Orleans
	South Wellfleet
	Truro
	Wellfleet
	West Chatham
	West Dennis
	West Harwich
PLYMOUTH	Brant Rock
	Bryantville
	Carver
	Duxbury
	Green Harbor
	Halifax
	Hanover
	Hanson
	Humarock
	Kingston
	Manomet
	Marshfield
	Marshfield Hills
	Monponsett
	North Carver
	North Marshfield
	North Pembroke
	Pembroke
	Plymouth
	Plympton
	South Carver
	White Horse Beach

Appendix R: Service Areas

TAUNTON	Berkley
	Dighton
	Lakeville
	Middleboro
	North Dighton
	Raynham
	Raynham Center
	Rehoboth
	Seekonk
	Taunton
WAREHAM	East Wareham
	Onset
	Wareham
	West Wareham

Service Area	City, Town
ATHOL	Athol
	Barre
	Baldwinville
	East Templeton
	Gilbertville
	Hardwick
	New Salem
	Orange
	Petersham
	Phillipston
	Royalston
	South Barre
	Templeton
	Warwick
	Wheelwright
FRAMINGHAM	Ashland
	Bellingham
	Blackstone
	Boxboro
	Douglas
	Dover
	East Douglas
	East Walpole
	Framingham
	Franklin
	Grafton
	Holliston
	Hopedale
	Hopkinton
	Hudson
	Linwood
	Manchaug
	Marlborough
	Maynard

Appendix R: Service Areas

	Medfield
	Medway
	Mendon
	Milford
	Millis
	Millville
	Natick
	Norfolk
	North Grafton
	Northborough
	Northbridge
	Oakdale
	Sherborn
	South Grafton
	South Walpole
	Southborough
	Stow
	Sudbury
	Sutton
	Upton
	Uxbridge
	Walpole
	Wayland
	West Upton
	Westborough
	Whitinsville
	Wilkinsonville
	Woodville
GARDNER-FITCHBURG	Ashburnham
	Ashby
	Ayer
	Berlin
	Bolton
	Clinton
	East Princeton
	Fitchburg
	Ft Devens
	Gardner
	Groton
	Harvard
	Hubbardston
	Lancaster
	Leominster
	Lunenburg
	Pepperell
	Princeton
	Shirley
	South Lancaster
	Sterling
	Still River
	Townsend
	West Groton

Appendix R: Service Areas

	Westminster
	Winchendon
	Winchendon Springs
SOUTHBRIDGE	Brimfield
	Brookfield
	Charlton
	Charlton City
	Charlton Depot
	Dudley
	East Brookfield
	Fiskdale
	Holland
	North Brookfield
	North Oxford
	North Uxbridge
	Oxford
	Southbridge
	Spencer
	Sturbridge
	Wales
	Warren
	Webster
	West Brookfield
	West Warren
WALTHAM	Auburndale
	Belmont
	Needham
	Newton
	Waltham
	Watertown
	Wellesley
	Weston
WORCESTER	Auburn
	Boylston
	Holden
	Jefferson
	Leicester
	Millbury
	New Braintree
	Oakham
	Paxton
	Rochdale
	Rutland
	Shrewsbury
	West Boylston
	Worcester

Service Area	City, Town
ADAMS	Adams
	Cheshire

Appendix R: Service Areas

	Clarksburg
	Drury
	Florida
	Hancock
	Lanesboro
	Monroe
	Monroe Bridge
	New Ashford
	North Adams
	Savoy
	Williamstown
	Windsor
GREENFIELD	Ashfield
	Bernardston
	Buckland
	Charlemont
	Colrain
	Conway
	Deerfield
	Erving
	Gill
	Greenfield
	Hawley
	Heath
	Lake Pleasant
	Leverett
	Leyden
	Montague
	Mount Hermon
	Northfield
	Rowe
	Shattuckville
	Shelburne
	Shelburne Falls
	Shutesbury
	South Deerfield
	Sunderland
	Turners Falls
	Wendell
	Wendell Depot
HOLYOKE	Belchertown
	Granby
	Holyoke
	Southampton
	South Hadley
NORTHAMPTON	Amherst
	Chesterfield
	Cummington
	Easthampton
	Goshen
	Hadley

Appendix R: Service Areas

	Hatfield
	Haydenville
	Leeds
	Middlefield
	Mill River
	North Amherst
	Northampton
	North Hatfield
	Plainfield
	Pelham
	West Chesterfield
	West Hatfield
	Westhampton
	Whately
	Williamsburg
	Worthington
PITTSFIELD	Alford
	Ashley Falls
	Becket
	Berkshire
	Dalton
	East Otis
	Egremont
	Glendale
	Great Barrington
	Hinsdale
	Housatonic
	Lee
	Lenox
	Lenox Dale
	Monterey
	Mount Washington
	New Marlborough
	North Egremont
	Otis
	Peru
	Pittsfield
	Richmond
	Sandisfield
	Sheffield
	South Egremont
	South Lee
	Southfield
	Stockbridge
	Tyringham
	Washington
	West Stockbridge
SPRINGFIELD	Bondsville
	Chicopee
	East Longmeadow
	Hampden
	Longmeadow

Appendix R: Service Areas

WESTFIELD	Ludlow
	Monson
	Palmer
	Springfield
	Thorndike
	Three Rivers
	Ware
	Wilbraham
	Agawam
	Blanford
	Chester
	Feeding Hills
	Granville
	Huntington
	Montgomery
	Russell
	Southwick
	Tolland
	Westfield
	West Springfield
	Woronoco

Appendix S: *High Cost Non-HCV drugs*

This Appendix contains the lists of high cost non-HCV drugs as defined in **Section 1**, that are subject to the risk sharing arrangement described in Section **4.5.G**. EOHHS may update this list from time-to-time.

For any specialty drugs listed below that can be billed either as National Drug Codes (NDC) through pharmacy Point of Service claims or as Healthcare Common Procedure Code System (HCPCS) codes through professional/institutional claims, EOHHS will account for the Contractor's spending on the drug through both claim types in the risk sharing arrangement described in **Section 4.5.G**.

Generic Code Numbers (GCN) and Label Names for non-injectable high cost specialty drugs

GCN	LABEL NAME
14778	FIRAZYR 30 MG/3 ML SYRINGE
28088	KALBITOR 10 MG/ML VIAL
31312	KALYDECO 150 MG TABLET
38138	KALYDECO 50 MG GRANULES PACKET
38139	KALYDECO 75 MG GRANULES PACKET
37273	OFEV 150 MG CAPSULE
37272	OFEV 100 MG CAPSULE
39008	ORKAMBI 200 MG-125 MG TABLET
98255	SOLIRIS 300 MG/30 ML VIAL
10495	CINRYZE 500 UNIT VIAL
31159	BERINERT 500 UNIT KIT
30182	RUCONEST 2,100 UNIT VIAL
32074	BERINERT 500 UNIT VIAL
19453	ZAVESCA 100 MG CAPSULE
36988	CERDELGA 84 MG CAPSULE
18997	FABRAZYME 35 MG VIAL
22348	FABRAZYME 5 MG VIAL
39941	CEREZYME 200 UNITS VIAL
62531	CEREZYME 400 UNITS VIAL
28299	VPRIV 400 UNITS VIAL
32078	ELELYSO 200 UNITS VIAL
19585	ALDURAZYME 2.9 MG/5 ML VIAL
97047	ELAPRASE 6 MG/3 ML VIAL
24744	NAGLAZYME 5 MG/5 ML VIAL
36083	VIMIZIM 5 MG/5 ML VIAL
33971	ADAGEN 250 UNITS/ML VIAL
26866	MYOZYME 50 MG VIAL - d/c'd 1/2015
39857	STRENSIQ 40 MG/ML VIAL
39858	STRENSIQ 80 MG/0.8 ML VIAL
39938	STRENSIQ 18 MG/0.45 ML VIAL
39939	STRENSIQ 28 MG/0.7 ML VIAL
39994	KANUMA 20 MG/10ML VIAL
42366	ORKAMBI 100 MG -125 MG TABLET
42836	SPINRAZA

GCN	LABEL NAME
42295	EXONDYS 51
42296	EXONDYS 51
26866	LUMIZYME 50MG VIAL
34137	RAVICTI
33927	GATTEX 5MG ONE-VIAL KIT
38146	CHOLBAM 50MG CAPSULE
38147	CHOLBAM 250MG CAPSULE
09628	KOATE-DVI 1,000 UNITS KIT
09629	KOATE-DVI 250 UNIT KIT
09634	KOATE-DVI 500 UNITS KIT
21647	ALPHANINE SD 1,500 UNITS VIAL
23381	NOVOSEVEN 1,200 MCG VIAL
23382	NOVOSEVEN 2,400 MCG VIAL
23383	NOVOSEVEN 4,800 MCG VIAL
23815	FEIBA VH IMMUNO 651-1,200 UNIT
23816	FEIBA VH IMMUNO 400-650 UNITS
25123	HELIXATE FS 250 UNIT VIAL
25124	HELIXATE FS 1,000 UNITS VIAL
25125	HELIXATE FS 500 UNIT VIAL
25127	REFACTO 500 UNITS VIAL
25129	KOATE-DVI 1,000 UNITS VIAL
25130	REFACTO 1,000 UNITS VIAL
25131	MONOCLATE-P 1,500 UNITS KIT
25132	KOATE-DVI 500 UNITS VIAL
25136	REFACTO 250 UNITS VIAL
25139	ALPHANATE 250-500 UNIT VIAL
25140	KONYNE 80 1,000 UNITS VIAL
25142	PROFILNINE SD 500 UNITS VIAL
25144	BEBULIN VH IMMUNO 200-1,200 UN
25147	PROFILNINE SD 1,000-1,500 UNIT
25148	PROFILNINE SD 1,500 UNITS VIAL
25151	KOATE-DVI 250 UNITS VIAL
25152	BENEFIX 1,000 UNIT VIAL
25153	BENEFIX 500 UNIT VIAL
25154	BENEFIX 250 UNIT VIAL
25748	MONARC-M 220-400 UNITS VIAL
25749	MONARC-M 1,701-2,000 UNITS VL
26335	FEIBA VH IMMUNO 1,750-3,250 IU
26449	HUMATE-P 600 UNITS KIT
26450	HUMATE-P 2,400 UNITS KIT
26451	HUMATE-P 1,200 UNITS KIT
26777	HEMOFIL M 220-400 UNITS VIAL
26778	HEMOFIL M 401-800 UNITS VIAL
26779	HEMOFIL M 801-1,700 UNITS VIAL
26780	HEMOFIL M 1,701-2,000 UNITS VL
26818	HELIXATE FS 2,000 UNIT VIAL

GCN	LABEL NAME
27008	RECOMBINATE 1,241-1,800 UNIT V
27332	ALPHANATE 250-100 UNIT VIAL
27333	ALPHANATE 500-200 UNIT VIAL
27334	ALPHANATE 1,000-400 UNIT VIAL
27335	ALPHANATE 1,500-600 UNIT VIAL
28276	WILATE 450-450 UNIT KIT
28277	WILATE 900-900 UNIT KIT
29034	NOVOSEVEN RT 8,000 MCG VIAL
29387	XYNTHA 3,000 UNIT SYRINGE KIT
29584	CORIFACT KIT
29983	MONONINE 1,000 UNITS KIT
30187	WILATE 500-500 UNIT KIT
30188	WILATE 1,000-1,000 UNIT KIT
30193	HEMOFIL M 801-1,700 UNITS VIAL
30194	HEMOFIL M 1,701-2,000 UNITS VL
30439	XYNTHA SOLOFUSE 1,000 UNIT KIT
30441	XYNTHA SOLOFUSE 2,000 UNIT KIT
31007	BENEFIX 3,000 UNIT KIT
31205	XYNTHA SOLOFUSE 250 UNIT KIT
31206	XYNTHA SOLOFUSE 500 UNIT KIT
32238	WILATE 500-500 UNIT VIAL
32239	WILATE 1,000-1,000 UNIT VIAL
32723	ADVATE 3,601-4,800 UNITS VIAL
34868	RIXUBIS 250 UNIT NOMINAL
34869	RIXUBIS 500 UNIT NOMINAL
34873	RIXUBIS 1,000 UNIT NOMINAL
34874	RIXUBIS 2,000 UNIT NOMINAL
34875	RIXUBIS 3,000 UNIT NOMINAL
35833	TRETTEN 2,500 UNIT VIAL
36333	ALPROLIX 500 UNIT NOMINAL
36334	ALPROLIX 1,000 UNIT NOMINAL
36335	ALPROLIX 2,000 UNIT NOMINAL
36336	ALPROLIX 3,000 UNIT NOMINAL
36657	ELOCTATE 250 UNIT NOMINAL
36658	ELOCTATE 500 UNIT NOMINAL
36662	ELOCTATE 750 UNIT NOMINAL
36663	ELOCTATE 1,000 UNIT NOMINAL
36664	ELOCTATE 1,500 UNIT NOMINAL
36665	ELOCTATE 2,000 UNIT NOMINAL
36666	ELOCTATE 3,000 UNIT NOMINAL
37015	ALPHANATE 2,000-800 UNIT VIAL
37321	OBIZUR 500 UNIT VIAL
37393	NOVOEIGHT 250 UNIT VIAL
37394	NOVOEIGHT 500 UNIT VIAL
37395	NOVOEIGHT 1,000 UNIT VIAL
37396	NOVOEIGHT 1,500 UNIT VIAL

GCN	LABEL NAME
37397	NOVOEIGHT 2,000 UNIT VIAL
37398	NOVOEIGHT 3,000 UNIT VIAL
38023	NUWIQ 250 UNIT VIAL PACK
38024	NUWIQ 500 UNIT VIAL PACK
38025	NUWIQ 1,000 UNIT VIAL PACK
38027	NUWIQ 2,000 UNIT VIAL PACK
38646	IXINITY 500 UNIT VIAL
38648	IXINITY 1,000 UNIT VIAL
38655	IXINITY 1,500 UNIT VIAL
39952	COAGADEX 250 (+/-) VIAL
39954	COAGADEX 500 (+/-) VIAL
40207	ADYNOVATE 250 (+/-) VIAL
40208	ADYNOVATE 500 (+/-) VIAL
40209	ADYNOVATE 1000 (+/-) VIAL
40213	ADYNOVATE 2000 (+/-) VIAL
40278	VONVENDI 650 (+/-)
40279	VONVENDI 1300(+/-)
40749	IDELVION 250 UNIT VIAL
40751	IDELVION 500 UNIT VIAL
40752	IDELVION 1,000 UNIT VIAL
40753	IDELVION 2,000 UNIT VIAL
40816	ALPROLIX 250 UNIT NOMINAL
41497	AFSTYLA 250 (+/-)
41499	AFSTYLA 500 (+/-)
41501	AFSTYLA 1000 (+/-)
41502	AFSTYLA 2000 (+/-)
41503	AFSTYLA 3000 (+/-
42556	ALPROLIX 4000 UNIT
50057	ALPHANATE 1,000-1,500 UNITS VL
89260	MONOCLATE-P 1,500 UNITS KIT
89434	HUMATE-P 500 UNITS KIT
89435	HUMATE-P 1,000 UNITS KIT
89436	HUMATE-P 2,000 UNITS KIT
91671	MONONINE 500 UNITS VIAL
91672	MONONINE 1,000 UNITS VIAL
91673	MONONINE 250 UNITS VIAL
91674	ALPHANINE SD 250-1,500 UNIT VL
91942	REFACTO 2,000 UNITS VIAL
92921	MONARC-M 401-800 UNITS VIAL
98600	BENEFIX 2,000 UNIT VIAL
98634	KOGENATE FS 3,000 UNITS VIAL
98764	ADVATE 1,801-2,400 UNITS VIAL
98830	ADVATE 1,201-1,800 UNITS VIAL
98831	ADVATE 401-800 UNITS VIAL
98832	ADVATE 801-1,200 UNITS VIAL
98833	ADVATE 200-400 UNITS VIAL

GCN	LABEL NAME
99696	NOVOSEVEN RT 1,000 MCG VIAL
99697	NOVOSEVEN RT 2,000 MCG VIAL
99698	NOVOSEVEN RT 5,000 MCG VIAL
99870	XYNTHA 250 UNIT KIT
99871	XYNTHA 500 UNIT KIT
99872	XYNTHA 1,000 UNIT KIT
99873	XYNTHA 2,000 UNIT KIT
43009	ADYNOVATE
43013	ADYNOVATE
43114	ELOCTATE 6000 UNIT
43115	ELOCTATE 4000 UNIT
43116	ELOCTATE 5000 UNIT
43169	IXINITY 250 UNIT VIAL
43171	IXINITY 2000 UNIT VIAL
43172	IXINITY 3000 UNIT VIAL

Healthcare Common Procedure Coding System – Injectable drugs

HCPC	HCPC Description
C9140	Injection, factor VIII (antihemophilic factor, recombinant) (Afstyla), 1IU
J7175	Injection, factor X, (human) 1U
J7179	Injection, von Willebrand factor (recombinant), (Vonvedi), 1U VWF:Rco
J7180	Injection, factor XIII (antihemophilic factor, human), 1 IU
J7181	Injection, factor XIII A-subunit (recombinant) per IU
J7182	Injection, factor VIII (antihemophilic factor, recombinant), (NovoEight), per IU
J7183	Injection, von Willebrand factor complex (human), Wilate, 1 IU vWF:RCo
J7185	Injection, factor VIII (antihemophilic factor, recombinant) (XYNTHA), per IU
J7186	Injection, antihemophilic factor VIII/von Willebrand factor complex (human), per factor VIII i.u.
J7187	Injection, von Willebrand factor complex (Humate-P), per IU VWF:RCO
J7188	Injection, vactor VIII, (antihemophilic factor, recombinant), per IU
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg
J7190	Factor VIII (antihemophilic factor, human) per IU
J7191	Factor VIII (antihemophilic factor (porcine)), per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU, not otherwise specified
J7193	Factor IX (antihemophilic factor, purified, nonrecombinant) per IU
J7194	Factor IX complex, per IU
J7195	Injection, Factor IX, per IU, NOS
J7198	Antiinhibitor, per IU
J7199	Hemophilia clotting factor, NOC
J7200	Injection, factor IX (antihemophilic factor, recombinant), (Nuwiq), 1U

HCPC	HCPC Description
J7201	Injection, factor IX, Fc fusion protein, (recombinant), Alprolix, 1U
J7202	Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, 1IU
J7205	Injection, factor VIII Fc fusion protein (recombinant, per IU
J7207	Injection, factor VIII (antihemophilic factor, recombinant) PEGylated, 1U
J7209	Injection, factor VIII, (antihemophilic factor, recombinant), (Nuwiq), 1U
J1744	FIRAZYR 30 MG/3 ML SYRINGE
J1290	KALBITOR 10 MG/ML VIAL
J1300	SOLIRIS 300 MG/30 ML VIAL
J0598	CINRYZE 500 UNIT VIAL
J0597	BERINERT 500 UNIT KIT
J0596	RUCONEST 2,100 UNIT VIAL
J0597	BERINERT 500 UNIT VIAL
J0180	FABRAZYME 35 MG VIAL
J0180	FABRAZYME 5 MG VIAL
J1786	CEREZYME 200 UNITS VIAL
J1786	CEREZYME 400 UNITS VIAL
J3385	VPRIV 400 UNITS VIAL
J3060	ELELYSO 200 UNITS VIAL
J1931	ALDURAZYME 2.9 MG/5 ML VIAL
J1743	ELAPRASE 6 MG/3 ML VIAL
J1458	NAGLAZYME 5 MG/5 ML VIAL
J1322	VIMIZIM 5 MG/5 ML VIAL
J2504	ADAGEN 250 UNITS/ML VIAL
J0220	MYOZYME 50 MG VIAL - d/c'd 1/2015
J2840	KANUMA 20 MG/10ML VIAL
C9484	EXONDYS 51
C9484	EXONDYS 51
J0221	LUMIZYME 50MG VIAL

HIV Prevention Drugs

GCN Code	LABEL NAME	Note
23152	TRUVADA	To apply toward the risk sharing arrangement described in Section **4.5.G,** member must only be using Truvada without any other HIV drugs during the 6 months prior and 6 months after the incurred date.

Appendix T

Commonwealth of Massachusetts Behavioral Health Minimum Fee Schedule Effective 1/1/2018				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90791	Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Interview Evaluation	$ 189.34
MH and SA OP Services	90791	Doctoral Level (MD / DO)	Psychiatric Diagnostic Interview Evaluation	$ 151.95
MH and SA OP Services	90791	Doctoral Level (PhD, PsyD, EdD)	Psychiatric Diagnostic Interview Evaluation	$ 130.44
MH and SA OP Services	90791	Intern (Master's)	Psychiatric Diagnostic Interview Evaluation	$ 58.71
MH and SA OP Services	90791	Intern (PhD, PsyD, EdD)	Psychiatric Diagnostic Interview Evaluation	$ 65.22
MH and SA OP Services	90791	Master's Level	Psychiatric Diagnostic Interview Evaluation	$ 117.41
MH and SA OP Services	90791	Nurse	Psychiatric Diagnostic Interview Evaluation	$ 131.51
MH and SA OP Services	90792	Doctoral Level (Child Psychiatrist)	Psychiatric Diagnostic Evaluation with Medical Services	$ 119.82
MH and SA OP Services	90792	Doctoral Level (MD / DO)	Psychiatric Diagnostic Evaluation with Medical Services	$ 103.92
MH and SA OP Services	90792	Nurse Psychiatric	Psychiatric Diagnostic Evaluation with Medical Services	$ 95.06
MH and SA OP Services	90832	Addiction Counselor	Individual Psychotherapy, approximately 20-30 minutes	$ 29.94
MH and SA OP Services	90832	Doctoral Level (Child Psychiatrist)	Individual Psychotherapy, approximately 20-30 minutes	$ 52.60
MH and SA OP Services	90832	Doctoral Level (MD / DO)	Individual Psychotherapy, approximately 20-30 minutes	$ 45.54
MH and SA OP Services	90832	Doctoral Level (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 44.22
MH and SA OP Services	90832	Intern (Master's)	Individual Psychotherapy, approximately 20-30 minutes	$ 21.44
MH and SA OP Services	90832	Intern (PhD, PsyD, EdD)	Individual Psychotherapy, approximately 20-30 minutes	$ 22.11
MH and SA OP Services	90832	Master's Level	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90832	Nurse	Individual Psychotherapy, approximately 20-30 minutes	$ 42.96
MH and SA OP Services	90833	Doctoral Level (MD / DO)	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90833	Nurse	Psychotherapy, 30 minutes, when Performed with an Evaluation and Management Service	$ 31.77
MH and SA OP Services	90834	Addiction Counselor	Intensive Outpatient Psychiatric Services	$ 53.34
MH and SA OP Services	90834	Doctoral Level (Child Psychiatrist)	Intensive Outpatient Psychiatric Services	$ 105.18
MH and SA OP Services	90834	Doctoral Level (MD / DO)	Intensive Outpatient Psychiatric Services	$ 92.42
MH and SA OP Services	90834	Doctoral Level (PhD, PsyD, EdD)	Intensive Outpatient Psychiatric Services	$ 87.17
MH and SA OP Services	90834	Intern (Master's)	Intensive Outpatient Psychiatric Services	$ 42.96
MH and SA OP Services	90834	Intern (PhD, PsyD, EdD)	Intensive Outpatient Psychiatric Services	$ 43.62
MH and SA OP Services	90834	Master's Level	Intensive Outpatient Psychiatric Services	$ 85.91
MH and SA OP Services	90834	Nurse	Intensive Outpatient Psychiatric Services	$ 85.91
MH and SA OP Services	90836	Doctoral Level (MD / DO)	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90836	Nurse	Psychotherapy, 45 minutes, when Performed with an Evaluation and Management Service	$ 51.58
MH and SA OP Services	90837	Doctoral Level (Child Psychiatrist)	Psychotherapy, 60 minutes	$ 105.18
MH and SA OP Services	90837	Doctoral Level (MD / DO)	Psychotherapy, 60 minutes	$ 92.42
MH and SA OP Services	90837	Doctoral Level (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 87.17
MH and SA OP Services	90837	Intern (Master's)	Psychotherapy, 60 minutes	$ 42.96

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Commonwealth of Massachusetts Behavioral Health Minimum Fee Schedule Effective 1/1/2018				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90837	Intern (PhD, PsyD, EdD)	Psychotherapy, 60 minutes	$ 43.62
MH and SA OP Services	90837	Master's Level	Psychotherapy, 60 minutes	$ 85.91
MH and SA OP Services	90837	Nurse	Psychotherapy, 60 minutes	$ 85.91
MH and SA OP Services	90838	Doctoral Level (MD / DO)	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90838	Nurse	Psychotherapy, 60 minutes, when Performed with an Evaluation and Management Service	$ 83.11
MH and SA OP Services	90847	Addiction Counselor	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 58.56
MH and SA OP Services	90847	Doctoral Level (Child Psychiatrist)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 128.56
MH and SA OP Services	90847	Doctoral Level (MD / DO)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 97.84
MH and SA OP Services	90847	Doctoral Level (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 91.34
MH and SA OP Services	90847	Intern (Master's)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 44.34
MH and SA OP Services	90847	Intern (PhD, PsyD, EdD)	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 45.66
MH and SA OP Services	90847	Master's Level	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90847	Nurse	Family Psychotherapy (conjoint psychotherapy) (with patient present)	$ 88.68
MH and SA OP Services	90853	Addiction Counselor	Group psychotherapy (other than of a multiple-family group)	$ 22.17
MH and SA OP Services	90853	Doctoral Level (Child Psychiatrist)	Group psychotherapy (other than of a multiple-family group)	$ 42.08
MH and SA OP Services	90853	Doctoral Level (MD / DO)	Group psychotherapy (other than of a multiple-family group)	$ 35.31
MH and SA OP Services	90853	Doctoral Level (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 32.60
MH and SA OP Services	90853	Intern (Master's)	Group psychotherapy (other than of a multiple-family group)	$ 15.00
MH and SA OP Services	90853	Intern (PhD, PsyD, EdD)	Group psychotherapy (other than of a multiple-family group)	$ 16.33
MH and SA OP Services	90853	Master's Level	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90853	Nurse	Group psychotherapy (other than of a multiple-family group)	$ 30.00
MH and SA OP Services	90882	Doctoral Level (Child Psychiatrist)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 46.46
MH and SA OP Services	90882	Doctoral Level (MD / DO)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 40.30
MH and SA OP Services	90882	Doctoral Level (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$21.79
MH and SA OP Services	90882	Intern (Master's)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$10.74
MH and SA OP Services	90882	Intern (PhD, PsyD, EdD)	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$10.91
MH and SA OP Services	90882	Master's Level	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$21.48
MH and SA OP Services	90882	Nurse	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers or institutions.	$ 34.87
MH and SA OP Services	90887	Doctoral Level (Child Psychiatrist)	Risk Management/Safety Planning Services	$ 46.46

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Commonwealth of Massachusetts Behavioral Health Minimum Fee Schedule Effective 1/1/2018				
Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	90887	Doctoral Level (MD / DO)	Risk Management/Safety Planning Services	$ 35.98
MH and SA OP Services	90887	Doctoral Level (PhD, PsyD, EdD)	Risk Management/Safety Planning Services	$ 21.79
MH and SA OP Services	90887	Intern (Master's)	Risk Management/Safety Planning Services	$ 10.74
MH and SA OP Services	90887	Intern (PhD, PsyD, EdD)	Risk Management/Safety Planning Services	$ 10.91
MH and SA OP Services	90887	Master's Level	Risk Management/Safety Planning Services	$ 21.48
MH and SA OP Services	90887	Nurse	Risk Management/Safety Planning Services	$ 31.14
MH and SA OP Services	96372	Doctoral Level (MD / DO)	Therapeutic, Prophylactic or Diagnostic Injection	$ 9.47
MH and SA OP Services	96372	Nurse	Therapeutic, Prophylactic or Diagnostic Injection	$ 9.47
MH and SA OP Services	99201	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient	$ 39.49
MH and SA OP Services	99201	Doctoral Level (MD / DO)	Evaluation and Management for New Patient	$ 34.25
MH and SA OP Services	99201	Nurse	Evaluation and Management for New Patient	$ 32.21
MH and SA OP Services	99202	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient	$ 68.41
MH and SA OP Services	99202	Doctoral Level (MD / DO)	Evaluation and Management for New Patient	$ 59.33
MH and SA OP Services	99202	Nurse	Evaluation and Management for New Patient	$ 55.25
MH and SA OP Services	99203	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient	$ 98.68
MH and SA OP Services	99203	Doctoral Level (MD / DO)	Evaluation and Management for New Patient	$ 85.58
MH and SA OP Services	99203	Nurse	Evaluation and Management for New Patient	$ 79.46
MH and SA OP Services	99204	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient	$ 149.09
MH and SA OP Services	99204	Doctoral Level (MD / DO)	Evaluation and Management for New Patient	$ 129.30
MH and SA OP Services	99204	Nurse	Evaluation and Management for New Patient	$ 121.14
MH and SA OP Services	99205	Doctoral Level (Child Psychiatrist)	Evaluation and Management for New Patient	$ 185.17
MH and SA OP Services	99205	Doctoral Level (MD / DO)	Evaluation and Management for New Patient	$ 160.59
MH and SA OP Services	99205	Nurse	Evaluation and Management for New Patient	$ 150.39
MH and SA OP Services	99211	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient	$ 19.88
MH and SA OP Services	99211	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient	$ 17.24
MH and SA OP Services	99211	Nurse	Evaluation and Management for an Established Patient	$ 15.71
MH and SA OP Services	99212	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient	$ 40.99
MH and SA OP Services	99212	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient	$ 35.55
MH and SA OP Services	99212	Nurse	Evaluation and Management for an Established Patient	$ 32.49
MH and SA OP Services	99213	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient	$ 73.98
MH and SA OP Services	99213	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient	$ 63.15
MH and SA OP Services	99213	Nurse	Evaluation and Management for an Established Patient	$ 54.84
MH and SA OP Services	99214	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient	$ 130.89
MH and SA OP Services	99214	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient	$ 86.37
MH and SA OP Services	99214	Nurse	Evaluation and Management for an Established Patient	$ 77.46
MH and SA OP Services	99215	Doctoral Level (Child Psychiatrist)	Evaluation and Management for an Established Patient	$ 130.89
MH and SA OP Services	99215	Doctoral Level (MD / DO)	Evaluation and Management for an Established Patient	$ 113.52
MH and SA OP Services	99215	Nurse	Evaluation and Management for an Established Patient	$ 103.84

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Unique Code/Modifier Combinations				
Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
MH and SA OP Services	99231	Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Maintenance, 15 minutes	$ 70.97
MH and SA OP Services	99231	Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Maintenance, 15 minutes	$ 53.88
MH and SA OP Services	99231	Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Maintenance, 15 minutes	$ 51.72
MH and SA OP Services	99231	Nurse	Subsequent Hospital Care for Eval and Maintenance, 15 minutes	$ 43.15
MH and SA OP Services	99232	Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Maintenance, 25 minutes	$ 106.46
MH and SA OP Services	99232	Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Maintenance, 25 minutes	$ 80.17
MH and SA OP Services	99232	Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Maintenance, 25 minutes	$ 76.96
MH and SA OP Services	99232	Nurse	Subsequent Hospital Care for Eval and Maintenance, 25 minutes	$ 64.21
MH and SA OP Services	99233	Doctoral Level (Child Psychiatrist)	Subsequent Hospital Care for Eval and Maintenance, 35 minutes	$ 141.96
MH and SA OP Services	99233	Doctoral Level (MD / DO)	Subsequent Hospital Care for Eval and Maintenance, 35 minutes	$ 106.90
MH and SA OP Services	99233	Doctoral Level (PhD, PsyD, EdD)	Subsequent Hospital Care for Eval and Maintenance, 35 minutes	$ 102.62
MH and SA OP Services	99233	Nurse	Subsequent Hospital Care for Eval and Maintenance, 35 minutes	$ 85.62
MH and SA OP Services	99251	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 20 minutes	$ 95.22
MH and SA OP Services	99251	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 20 minutes	$ 72.27
MH and SA OP Services	99251	Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 20 minutes	$ 69.38
MH and SA OP Services	99251	Nurse	Initial Inpatient Consultation, 40 minutes	$ 57.88
MH and SA OP Services	99252	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 40 minutes	$ 142.83
MH and SA OP Services	99252	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 40 minutes	$ 107.56
MH and SA OP Services	99252	Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 40 minutes	$ 103.25
MH and SA OP Services	99252	Nurse	Initial Inpatient Consultation, 40 minutes	$ 86.15
MH and SA OP Services	99253	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 55 minutes	$ 190.43
MH and SA OP Services	99253	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 55 minutes	$ 143.40
MH and SA OP Services	99253	Doctoral Level (PhD, PsyD, EdD)	Initial Inpatient Consultation, 55 minutes	$ 137.67
MH and SA OP Services	99253	Nurse	Initial Inpatient Consultation, 55 minutes	$ 114.86
MH and SA OP Services	99254	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation, 80 minutes	$ 255.41
MH and SA OP Services	99254	Doctoral Level (MD / DO)	Initial Inpatient Consultation, 80 minutes	$ 191.80
MH and SA OP Services	99254	Nurse	Initial Inpatient Consultation, 80 minutes	$ 153.64
MH and SA OP Services	99255	Doctoral Level (Child Psychiatrist)	Initial Inpatient Consultation - Comprehensive	$ 336.47
MH and SA OP Services	99255	Doctoral Level (MD / DO)	Initial Inpatient Consultation - Comprehensive	$ 252.34
MH and SA OP Services	99255	Nurse	Initial Inpatient Consultation - Comprehensive	$ 202.12
MH and SA OP Services	99402	Doctoral Level (PhD, PsyD, EdD)	Psychological Testing, 30 minutes	$ 40.98
MH and SA OP Services	99402	Intern (PhD, PsyD, EdD)	Psychological Testing, 30 minutes	$ 20.50
MH and SA OP Services	99404	Doctor (Child / Adolescent MD / DO)	Counseling and/or Risk Factor Reduction Intervention, 60 minutes	$ 153.27
MH and SA OP Services	99404	Doctoral Level (MD / DO)	Counseling and/or Risk Factor Reduction Intervention, 60 minutes	$ 177.11
MH and SA OP Services	99404	Nurse	Counseling and/or Risk Factor Reduction Intervention, 60 minutes	$ 153.27
Diversionary Services	H0015	Complex Level of Care	Enhanced Structured Outpatient Addiction Program (SOAP) with Motivational Interviewing	$ 80.30

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Diversionary Services	H0015	Intermediate Level Of Care	Structured Outpatient Addiction Program (SOAP) with Motivational Interviewing	$ 71.59
Diversionary Services	H2012	+	Day Treatment	$ 12.83
Diversionary Services	H2012	Complex Level of Care	Day Treatment - Enhanced	$ 13.22
Diversionary Services	H2015	+	CSP Community Support	$ 9.53
Diversionary Services	H2015	Multi-Disciplinary Team	CSP Community Support - Cultural Broker	$ 10.39
Diversionary Services	H2016	+	RSN - Recovery Support Navigator	$ 17.30
Diversionary Services	H2020	+	Dialectical Behavior Therapy	$ 26.50
Diversionary Services	S9484	+	Urgent Outpatient Services	$ 147.57
Substance Abuse	97811	Substance Abuse Program	Adult or Adolescent Acupuncture	$ 19.84
Substance Abuse	H0014	+	Outpatient Detox - Adult or Adolescent	$ 227.65
Substance Abuse	H0020	+	Methadone Services - Dosing	$ 11.43
Substance Abuse	H0020	Family/ Couple With Client Present	Methadone Services - Family	$ 84.79
Substance Abuse	H0020	Group Setting	Methadone Services - Group	$ 28.68
Substance Abuse	H0020	Intermediate Level Of Care	Methadone Services - Individual	$ 41.16
ESP Services (0 to 18 years of age)	S9485	Child/Adolescent Program	Mobile Crisis Intervention Services	$ 504.97
Adult ESP Services	90887	ESP	Risk Management/Safety Planning Services	$ 18.85
Adult ESP Services	99215	ESP	Evaluation and Management for an Established Patient	$ 160.63
Adult ESP Services	S9485	Doctoral Level (MD / DO)	Mobile Non-emergency Department	$ 584.65
Adult ESP Services	S9485	HW	Mobile Non-Emergency Department - Uninsured	$ 538.00
Adult ESP Services	S9485	Mental Health Program	Community Based	$ 530.84
Adult ESP Services	S9485	HK	Community Based - Uninsured	$ 488.00
Adult ESP Services	S9485	Adult Program	Hospital Emergency Room	$ 504.97
Adult ESP Services	S9485	ESP	Adult Community Crisis Stabilization Day 1	$ 362.17
Adult ESP Services	S9485	Intermediate Level Of Care	Adult Community Crisis Stabilization Day 2-5	$ 504.97
Adult ESP Services	S9485	Complex Level of Care	Adult Community Crisis Stabilization Day 6 and After	$ 362.17
Other Outpatient	90870	+	Electroconvulsive therapy (includes necessary monitoring)	$ 630.95
Other Outpatient	96101	Doctoral Level (PhD, PsyD, EdD)	Psychological testing	$ 91.39
Other Outpatient	96101	Intern (Master's)	Psychological testing	$ 45.70
Other Outpatient	96111	Doctoral Level (PhD, PsyD, EdD)	Developmental Testing/Learning Disorders	$ 180.72
Other Outpatient	96118	Doctoral Level (PhD, PsyD, EdD)	Neuropsychological Testing Battery	$ 91.39
Other Outpatient	96119	Intern (Master's)	Neuropsych Testing by tec	$ 45.70
Other Outpatient	H0032	Master's Level	Mental Health Service Plan Development by a Non-Physician	$ 166.67
Other Outpatient	H0046	Doctoral Level (MD/DO) Child/Adolesc	Collateral Contact	$ 28.30
Other Outpatient	H0046	Doctoral Level (MD/DO) Adult	Collateral Contact	$ 23.11
Other Outpatient	H0046	Doctoral Level (PsyD, EdD, PhD)	Collateral Contact	$ 21.79
Other Outpatient	H0046	Master's Level	Collateral Contact	$ 21.48
Other Outpatient	H0046	Intern (Master's Level)	Collateral Contact	$ 11.83

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Category of Service	**Procedure Code**	**Modifier Group**	**Procedure Description**	**Unit Cost**
Other Outpatient	H0046	Intern (PsyD, EdD, PhD)	Collateral Contact	$ 11.83
Other Outpatient	H0046	Addiction Counselor	Collateral Contact	$ 14.64
Other Outpatient	H0046	Nurse	Collateral Contact	$ 14.64
Other Outpatient	H2028	Addiction Counselor	ASAP (Assessment for Safe and Appropriate Placement)	$ 22.79