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CENTER FOR MEDICARE AND MEDICAID INNOVATION
7500 SECURITY BOULEVARD
BALTIMORE, MD 21244

REQUEST FOR RESPONSES

FROM INTEGRATED CARE ORGANIZATIONS

RFR # 12CBEHSDUALSICORFR

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SECTION 1. INTRODUCTION

Section 1.1 Overview of the Duals Demonstration

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (EOHHS) administers the Commonwealth of Massachusetts Medicaid program (called MassHealth) pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers, including, as applicable here, Section 1115A of the Social Security Act. EOHHS seeks responses from Integrated Care Organizations (ICOs) to participate in the 1115A Demonstration program to integrate the delivery and financing of Medicare and Medicaid services for adults ages 21 through 64 who are eligible for both Medicare and Medicaid at the time of enrollment (Dual Eligibles). The purpose of this three-year Duals Demonstration (Demonstration) is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for Dual Eligible Members. (See **Section 2** for definitions of terms and acronyms used in this RFR.)

ICOs procured under this Request for Responses (RFR) will be accountable for the delivery and management of all covered medical, Behavioral Health, and Long-Term Services and Supports (LTSS) for their Enrollees. ICOs will be required to provide the full array of Medicare and Medicaid services, but also will have significant flexibility to provide a range of community-based services and supports as alternatives to or means to avoid high-cost traditional services. ICOs also have the flexibility to promote enhancement of the health care workforce through the use of Community Health Workers and qualified peers. These flexibilities must be tailored to the needs of individual Enrollees.

The Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services administers the Medicare and Medicaid programs. CMS authorizes the Demonstration under Section 1115A of the Social Security Act. The Demonstration requires compliance with Medicare Advantage regulations in Part C of Title XVIII and 42 C.F.R. § 422 and Medicare Part D regulations in Title XVIII and 42 C.F.R. § 423, except to the extent that variances are approved. Any approved waivers and variances will be documented in the CMS-EOHHS *Memorandum of Understanding Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (MOU).*

EOHHS is issuing this RFR pursuant to the provisions of 801 CMR 21.00, which govern the procurement of services by State agencies, including the issuance of RFRs for services in excess of $50,000. CMS and EOHHS make no guarantee that any services will be purchased as a result of this RFR or from any Contract resulting from this RFR.

Implementation of the Demonstration will provide essential experience and knowledge to federal and State policymakers about the impact of this innovative service delivery model and financing arrangement, designed to bring a better coordinated, person-centered focus to meeting the complex functional and health care needs of non-elderly adults with

disabilities. The characteristics and consequent needs of the eligible population are not homogeneous, and ICOs are expected to tailor services to each Enrollee. The population includes:

- Adults with physical disabilities;
- Adults with Developmental Disabilities;
- Adults with Serious Mental Illness;
- Adults with substance use disorders;
- Adults with disabilities who have multiple chronic illnesses or functional or cognitive limitations; and
- Adults with disabilities who are homeless.

Section 1.2 Program Description Highlights

Dual Eligible individuals under age 65 have among the most complex care needs of any MassHealth or Medicare members, yet the current delivery system for this population strains, unevenly and inefficiently, to meet those needs. The Demonstration seeks to make available comprehensive services, beyond currently covered standard Medicare and Medicaid benefits, which address members' full range of health and functional needs. ICOs will deliver the services in a setting of integrated care management and care coordination through an interdisciplinary care team. Within this model, ICOs will have significant flexibility to innovate around care delivery and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost traditional services, if indicated by the Enrollee's needs and care plan.

The Demonstration will employ a payment structure that aligns the incentives between Medicare and Medicaid. EOHHS and CMS will combine Medicaid and Medicare funding to contract with ICOs using a blended global financial arrangement to provide integrated, comprehensive care for Dual Eligible adults aged 21 through 64. ICOs will employ or contract with Primary Care Providers (PCPs) that will deliver team-based integrated Primary and Behavioral Health care to Enrollees, and coordinate their care across Providers. The Interdisciplinary Care Team (ICT), led by a Primary Care or Behavioral Health clinician and Care Coordinator, will arrange for the availability of care and services by specialists, hospitals, and Providers of LTSS and other community supports. For Enrollees with LTSS needs, an Independent Living and LTSS Coordinator will join the ICT to facilitate access to LTSS and other community-based supports and Providers. Certain high-risk Enrollees also will have access to Clinical Care Management services, which provide more intensive clinical monitoring and follow-up in addition to care coordination.

Integration of Medicare and Medicaid will, to the extent reasonably possible, extend to all administrative processes, including outreach and education functions, Demonstration oversight, customer service, and Appeals and Grievances. EOHHS and CMS will monitor ICOs' performance using a meaningful set of quality metrics. Enrollment in the Demonstration will be voluntary and will be supported by clear, useful and accessible

information and facilitated by a neutral and impartial enrollment broker. Eligible Members who do not express a preference regarding enrollment will be assigned by MassHealth to an ICO serving the county in which they live. Enrollees will have the ability to change ICOs or opt out of the Demonstration at any time. EOHHS wishes to preserve relationships between Enrollees and eligible providers, where possible, and will require ICOs to conduct outreach to current providers serving the target population, and continually enroll new providers.

Section 1.3 ICO Procurement Process

EOHHS and CMS will select ICOs through a joint selection process that will take into account previous performance in Medicare and Medicaid, and ensure Respondents have met CMS's threshold requirements (see **Section 11.4).** While this RFR serves as the vehicle for procuring ICOs for the Demonstration, CMS has issued various Medicare requirements necessary for interested Respondents to qualify for participation in the Demonstration, including submission of a *2013 Capitated Financial Alignment Demonstration Application* by May 24, 2012.

This RFR includes MassHealth-specific requirements and qualifications to become an ICO under the Demonstration. The RFR requires all Respondents to provide the information EOHHS needs to determine whether these qualifications have been met. ICO selection will include CMS and EOHHS review of applications submitted via CMS's Health Plan Management System (HPMS), and EOHHS evaluation of all RFR responses, as outlined in **Sections 11** through **13**.

Section 1.4 Number of Contract Awards and ICO Service Areas

A. EOHHS seeks to offer ICO enrollment to eligible Members statewide, and may limit selection to no more than five qualifying Respondents in each county in the Commonwealth.

B. Respondents may submit a proposal for a service area comprised of full or partial counties, as approved by CMS and EOHHS. Respondents may bid to provide services in as few as one or as many as all 14 counties or in partial counties. In their RFR response, Respondents must specify each county or partial county they wish to serve. In addition, Respondents must note any differences in the Service Area proposed in their Response versus the Service Area described in the Respondent's Capitated Financial Alignment (CFA) Demonstration Plan Application submitted to CMS. If there are any differences, the Respondent must update its Application via email to CMS no later than June 22, 2012. Those updates may only constitute a drop of one or more full or partial counties; a Respondent may not add to their Service Area at any point after the initial Application has been submitted to CMS.

C. Respondents may be awarded a Contract for all, some, or none of their proposed counties or partial counties. Respondents shall accept Contract awards in all counties for which they are selected whether or not they are selected for each county for which

they bid. ICOs covering a partial county will not receive Auto-assignments in that county (see **Section 3.3**).

Section 1.5 Contract Term

As a result of this RFR, CMS and EOHHS intend to enter into a single Contract with each selected ICO to provide Covered Services (see **Section 4.2**) to Enrollees for an initial three-year Contract term effective April 1, 2013, through December 31, 2016.

Section 1.6 Service Provision

Any Respondent that becomes an ICO shall provide Covered Services, as described in **Section 4.2**, to all Enrollees where Medically Necessary in accordance with the requirements of the Contract.

The ICO shall comply with all Contract requirements including, but not limited to, provisions governing the delivery of services and the performance of ICO responsibilities thereunder.

Section 1.7 Respondent Qualifications

CMS and EOHHS seek to contract with multiple qualified Respondents to deliver and integrate the Covered Services described in **Section 4.2**. To be considered for a Contract award pursuant to this RFR, a Respondent, in addition to all other requirements specified in this RFR, must have met all Medicare requirements established by CMS. CMS shall determine whether all such requirements have been met. A Respondent shall not be considered for an ICO Contract unless CMS determines that all established Medicare requirements have been met. The following is a list of requirements that CMS has identified to EOHHS, as well as EOHHS requirements:

A. Medicare requirements and qualifications, as described in CMS's January 25, 2012 Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans; March 29, 2012 Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013; and 2013 Capitated Financial Alignment Demonstration Application, and other guidance materials. These documents describe mandatory qualification criteria in areas such as:

1. Notice of Intent to Apply (NOIA) for Capitated Financial Alignment Demonstration Contracts;
2. Medicare past performance analyses;
3. Part D benefit, including formulary and Medication Therapy Management Program (MTMP) submission and approval;
4. Solvency/Licensure;
5. Fiscal soundness;

6. Administrative and management arrangements;
7. Network adequacy for Medicare medical services and prescription drugs;
8. Evidence-based Model of Care (MOC)[1]; and
9. Benefits provision and coordination/integration.

B. MassHealth requirements specified in this RFR, including:

1. Capability and willingness to perform all of the functions detailed in **Sections 3, 4** and **5** of this RFR; and
2. Satisfaction of all qualifications required by **Sections 9** and **10** of this RFR.

SECTION 2. DEFINITIONS

The following terms appearing capitalized throughout this RFR and appendices have the following meanings, unless the context clearly indicates otherwise.

1115 MassHealth Demonstration – demonstration authorized pursuant to Section 1115 of the Social Security Act that permits the U.S. Secretary of Health and Human Services to exempt the Massachusetts Medicaid program from compliance with certain Title XIX requirements and authorizes the State to make expenditures that would not be permitted under Title XIX.

1915(c) Waivers or Home and Community-Based Services Waivers (HCBS Waivers) – a federally approved program operated under Section 1915(c) of the Social Security Act that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community services to certain Medicaid beneficiaries who need a level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Abuse – actions or inactions by Providers (including ICOs) and/or Members/Enrollees that are inconsistent with sound fiscal, business or medical practices, and that result in unnecessary cost to the MassHealth program, including but not limited to practices that result in MassHealth reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care.

Accountable Care Organization (ACO) – a provider-based organization that takes accountability for the cost and quality of care delivered to a patient across the spectrum of care delivery.

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[1] Note: For all capitated model demonstrations with 2013 effective enrollment dates, CMS has extended the timeline for prospective integrated entities to submit MOCs via the Health Plan Management System (HPMS). The original requirement was for integrated entities to submit their MOCs by May 24, 2012 as part of their Demonstration Applications to CMS. That date has been extended, and the new deadline will be shared with integrated entities via HPMS.

Activities of Daily Living (ADLs) – certain basic tasks required for daily living, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, get around inside the home, and manage incontinence.

Adverse Action – any one of the following actions or inactions by the Contractor shall be considered an Adverse Action:

1. the failure to provide Covered Services in a timely manner in accordance with the accessibility standards in **Section 4.5**;
2. the denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;
3. the reduction, suspension, or termination of a previous authorization by the Contractor for a service;
4. the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue.

Agency for Healthcare Research and Quality (AHRQ) – a federal agency that conducts the Medical Expenditure Panel Survey (MEPS).

Aging Services Access Point (ASAP) – an entity organized under Massachusetts General Law (M.G.L.) c. 19 § 4B that contracts with the Executive Office of Elder Affairs to manage the Home Care Program in Massachusetts and that performs case management, screening, and authorization activities for certain long term care services.

Alternative Formats – provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats include, but are not limited to Braille, large font (at least 16 point), computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf, audio tape, videotape, and Enrollee information read aloud to an Enrollee by an Enrollee services representative.

Alternative Payment Methodologies – methods of payment that compensate providers for the provision of health care or support services, including but not limited to shared savings and shared savings/shared risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and Global Payments. Payments based on traditional Fee-For-Service methodologies shall not be considered Alternative Payment Methodologies.

Appeal – an Enrollee's request for formal review of an action of a Participating Plan (ICO).

Auto-assignment – a process by which MassHealth will select an ICO on behalf of an eligible Member who has not expressed a choice of ICO or to opt out of the Demonstration under specific terms and circumstances described in **Section 3.3.A**. This is also referred to as passive enrollment.

Behavioral Health (BH) – mental health and substance use disorders or conditions.

Behavioral Health Diversionary Services – 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 treatment (see **Appendix A**), or to provide intensive support to maintain functioning in the community.

Behavioral Health Inpatient Services – mental health or substance use disorder services, or both, set forth in **Appendix B**, which are provided in a 24-hour setting, such as a hospital.

Behavioral Health Outpatient Services – mental health and substance use disorder services set forth in **Appendix B**, which are provided in an ambulatory care setting, such as a mental health or substance use clinic, hospital outpatient department, community mental health center, or Provider's office.

Care Coordinator – a provider-based clinician or other trained individual who is employed or contracted by the Primary Care Provider. The Care Coordinator is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

Centers for Medicare and Medicaid Services (CMS) – the federal agency under the U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.

Centralized Enrollee Record – centralized and comprehensive documentation, containing information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions. The documentation will also capture/maintain data on certain demographic elements as delineated in withhold measures (e.g., race, ethnicity, disability type, primary language and homelessness). See **Section 4.10** for more information about the contents of the Centralized Enrollee Record.

Clinical Care Management – a set of services provided by a Clinical Care Manager that comprise intensive monitoring, follow-up, and care coordination, clinical management of high-risk Enrollees, as further described in **Section 4.6.C**.

Clinical Care Manager – a licensed Registered Nurse or other individual, employed by the Primary Care Provider or the ICO and licensed to provide Clinical Care Management.

Community-Based Organization – private, non-profit agencies or organizations serving specific geographic and/or disability or elder communities that are culturally and linguistically competent and that have experience, expertise and staff skilled in the following:

- providing information and referral to community-based long-term services and supports (LTSS) of all types;
- conducting assessments of the need for LTSS;
- understanding and communicating appropriately with Members with disabilities of all types and with elders;
- advocating for Members and their needs for LTSS; and
- organizing, arranging for and monitoring the provision of LTSS.

Community Health Workers – trained health workers who apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out one or more of the following roles:

- Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers;
- Bridging/culturally mediating between individuals, communities, and health and human services, including actively assisting Enrollees with access to community resources;
- Assuring that people access the services they need;
- Assisting Enrollees to engage in wellness activities as well as chronic disease self-management;
- Providing direct services, such as informal counseling, social support, care coordination, and health screenings; and
- Conducting home visits to assess health risk and mitigation opportunities in the home setting.

Community Support Services – services provided in a home or other community setting that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Co-Morbid Disorders – the simultaneous manifestation of a physical disorder and a Behavioral Health disorder, or multiple different physical health disorders.

Co-Occurring Disorders (or Dual Diagnoses) – medical conditions involving the simultaneous manifestation of a mental health disorder and a substance use disorder.

Consumer – a Medicare or MassHealth Member, ages 21 through 64, or the spouse, sibling, child or unpaid primary caregiver of a Medicare or MassHealth Member who is ages 21 through 64.

Contract – the participation agreement that EOHHS has with an ICO, setting forth the terms and conditions pursuant to which an organization may participate in the Duals Demonstration.

Contract Year – a 12-month period commencing April 1 and ending March 31, unless otherwise specified by EOHHS.

Contractor – any entity approved by CMS and EOHHS to be an ICO and that enters into a Contract to meet the purposes specified in this RFR and that Contract.

Covered Services – the set of services to be offered by the Integrated Care Organizations (ICOs).

Cultural Competence – understanding those values, beliefs, and needs that are associated with patients' age or gender or with their racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Developmental Disability – a severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the individual attains age 22;
- Is likely to continue indefinitely; and
- Results in substantial functional limitations in three or more of major life activities.

Examples include autism; behavior disorder; brain injury; cerebral palsy; Down syndrome; fetal alcohol syndrome; intellectual disability; and spina bifida.

Disability Culture – a set of artifacts, beliefs, and expressions created by people with disabilities to describe their own life experiences from a social, political and personal dynamic. Disability Culture emphasizes and supports the human ideals of equality, self-direction and opportunity, and arises from a unified struggle for civil rights, personal independence and cultural respect. Disability Culture is continually evolving as it incorporates the distinct history and contemporary experience of "difference" that includes attributes such as race, ethnicity, gender, age and sexual orientation.

Discharge Planning – the evaluation of an Enrollee's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.

Dual Eligible – for the purposes of this document, any person, aged 21 up to 64 at the time of enrollment, who is simultaneously qualified for MassHealth Standard or CommonHealth and Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. and who does not have any other comprehensive public or private health care coverage.

Duals Demonstration (Demonstration) – the State Demonstration to Integrate Care for Dual Eligible Individuals in Massachusetts. The Demonstration is a partnership between Massachusetts and CMS to integrate care and financing for Dual Eligibles. The purpose of this Demonstration is to improve quality of care and reduce health disparities, improve health and functional outcomes, and reduce costs.

Eligibility Redetermination – the process by which MassHealth Members must complete certain forms and provide certain verifications in order to establish continued MassHealth eligibility. This process may be required annually, or in response to certain changes in the Member's circumstances.

Eligibility Representative – a friend, family member, relative, or other person chosen by the Member to help with some or all of the responsibilities of applying for or getting MassHealth benefits. This may include enrolling in and receiving services from an ICO. An Eligible Representative may fill out an application or review form and other MassHealth eligibility forms, give MassHealth proof of information given on applications, review forms, and other MassHealth forms, reports changes in a Member's income, address, or other circumstances, and get copies of all MassHealth eligibility notices sent to the Member.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in placing the health of an Enrollee or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

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 are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

Emergency Service Program (ESP) – services provided through designated, contracted providers which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization. See **Appendix G** for a list of ESP providers.

Enrollee – any Dual Eligible Member who is enrolled in an ICO.

Enrollee Services Representative (ESR) – an employee of the ICO who assists Enrollees with questions and concerns.

Executive Office of Health and Human Services (EOHHS) – the single State agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, the § 1115 MassHealth Demonstration, this Demonstration under § 1115A, and other applicable laws and waivers.

Fee-For-Service (FFS) – a method of paying an established fee for a unit of health care service.

Fiscal Intermediary – an entity operating as a Fiscal Employer Agent (F/EA) under section 3504 of IRS code, Revenue Procedure 70-6, and as modified by IRS Proposed Notice 2003-70 and contracting with EOHHS to perform Employer-Required Tasks and related Administrative Tasks connected to Self-directed PCA Services on behalf of Members who chose to Self-direct PCA Services including, but not limited to, issuing PCA checks and managing employer-required responsibilities such as purchasing workers' compensation insurance, and withholding, filing and paying required taxes.

Fraud – an intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of provider fraud include: lack of referrals by PCPs to specialists, improper coding, billing for services never rendered, inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

Functional Status – measurement of the ability of individuals to perform Activities of Daily Living (ADLs) (e.g., mobility, transfers, bathing, dressing, toileting, eating, and personal hygiene) and Instrumental Activities of Daily Living (IADLs) (e.g., meal preparation, laundry, and grocery shopping).

Global Payment – Consolidated payment to entities or providers for all or most of the care that their patients may require over a certain period, such as a month or year.

Grievance – any expression of dissatisfaction by an Enrollee about any action or inaction by the Contractor. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of Contractor, or failure to respect the Enrollee's rights.

Health care Acquired Condition (HCAC) – a condition occurring in any inpatient hospital setting, which Medicare designates as hospital-acquired conditions HACs) pursuant to Section 1886 (d)(4)(D)(iv) of the Social Security Act (SSA)(as described in Section 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis

(DVT/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Health Home – as defined in Section 1945 of the Social Security Act, a designated provider, a team of health care professionals operating with the designated provider, or a health team that provides access to comprehensive services including medical care, behavioral health care, and long term services and supports (LTSS) to populations with chronic conditions. Health Homes include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – federal legislation (Pub. L. 104-191), enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, fraud and abuse in health insurance and health-care delivery, simplify the administration of health insurance, and protect the confidentiality and security of individually identifiable health information.

Healthcare Effectiveness Data and Information Set (HEDIS) – a standardized set of health plan performance measures developed by the National Committee for Quality Assurance (NCQA) and utilized by EOHHS and other purchasers and insurers.

Home and Community-Based Services (HCBS) Waiver – see "1915(c) Waivers."

Home and Community-Based Services (HCBS) Waiver Services – a set of long-term services and supports as defined in a CMS-approved HCBS Waiver and available to participants eligible for and enrolled in the applicable HCBS Waiver.

Housing First – an approach to chronic homelessness that is an alternative to a system of emergency shelter/transitional housing progressions and the practice of moving homeless individuals through different levels of housing. Housing First provides opportunities for the homeless individual or household to move immediately from the streets or homeless shelters into their own apartments. Its approach is based on the concept that a homeless individual or household's first and primary need is to obtain stable housing, and that other issues (i.e., medical, recovery) that may affect the individual can and should be addressed once housing is obtained.

Independent Living Center (ILC) – a Consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities; and provides an array of independent living services. ILCs promote a philosophy of independent living, including a philosophy of Consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy.

Independent Living and Long-Term Supports Coordinator (IL-LTSS Coordinator) – a coordinator employed by a Community-Based Organization (CBO) and contracted by the ICO to support the Enrollee with the coordination of LTSS and to provide expertise and community supports to the Enrollee and his/her care team. The IL-LTSS Coordinator's primary responsibilities will be to: ensure person-centered care planning and provision of LTSS in ways that promote independent living, counsel potential Enrollees; provide communication and support needs, and act as an independent facilitator and liaison between the Enrollee, the ICO and their service providers.

Individualized Care Plan (ICP) – the plan of care developed by an Enrollee and an Enrollee's Interdisciplinary Care Team.

Institution – a skilled nursing facility, chronic or rehabilitation hospital, or psychiatric hospital.

Instrumental Activities of Daily Living (IADLs) – certain basic environmental tasks required for daily living, including the ability to prepare meals, do housework, laundry, and shopping, get around outside, use transportation, manage money, perform care and maintenance of wheelchairs and adaptive devices, and use the telephone.

Integrated Care Organization (ICO) – a health plan or provider-based organization contracted to and accountable for providing integrated care to Enrollees.

Interdisciplinary Care Team (ICT) – a team of Primary Care Provider, Care Coordinator, IL-LTSS Coordinator and other individuals, including Behavioral Health providers, at the discretion of the Enrollee that work with the Enrollee to develop, implement, monitor and maintain the Individualized Care Plan.

Key Operations Services Vendor – EOHHS's enrollment broker, formerly called the Customer Service Team (CST), which provides Members with a single point of access to a wide range of customer services, including enrolling Members into ICOs.

Long-Term Services and Supports (LTSS) – a wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include, but are not limited to, Durable Medical Equipment, home health, therapies, assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

MassHealth – the medical assistance and benefit programs (Medicaid) administered by the Executive Office of Health and Human Services.

MassHealth CommonHealth – a MassHealth coverage type as specified at 130 CMR 505.004 that offers health benefits to certain working and non-working disabled adults between the ages of 19 and 64.

MassHealth Standard – a MassHealth coverage type as specified at 130 CMR 505.002 that offers a full range of health benefits to certain eligible Members, including families, children under age 18, pregnant women, disabled individuals under 65, and elders.

Material Subcontractor – any entity to which the Contractor delegates the responsibility to meet all the requirements of any complete, enumerated subsection as allowed under the Contract.

Medicaid – the program of medical assistance benefits under Title XIX and Title XXI of the Social Security Act and various demonstrations and waivers thereof (see also "MassHealth").

Medicaid Fraud Division (MFD) – a division of the Massachusetts Office of the Attorney General that is dedicated to investigating cases of suspected Fraud or Abuse.

Medicaid Management Information System (MMIS) – the management information system of software, hardware and manual processes used to process claims and to retrieve and produce eligibility information, service utilization and management information for Members.

Medically Necessary or Medical Necessity – services:

- (per Medicare) that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y.
- (per MassHealth):
    - that are provided in accordance with MassHealth regulations at 130 CMR 450.204;
    - which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
    - for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and MassHealth.

Medicare – Title XVIII of the Social Security Act, the federal health insurance program for people age 65 and older, people under 65 with certain disabilities, and people with End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A provides coverage of inpatient hospital services and

services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

Medicare Advantage – the Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at Part C, and 42 C.F.R. § 422.

Member – a person enrolled in MassHealth.

Minimum Data Set – Home Care (MDS-HC) – a clinical screening system using proprietary tools developed by interRAI Corporation, which assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for nursing facility residents.

Network Provider – an appropriately credentialed and licensed individual, facility, agency, Institution, organization or other entity that has a written agreement with the Contractor, or any subcontractor, for the delivery of services covered under the Contract.

Network Management –the activities, strategies, policies and procedures, and other tools used by the Contractor in the development, administration and maintenance of the collective group of health care Providers under contract to deliver Covered Services.

Other Provider Preventable Condition (OPPC) – a condition that meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 C.F.R. 447.26(b). OPPCs may occur in any health care setting and are divided into two sub-categories:

1. National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:
   a) Wrong surgical or other invasive procedure performed on a patient;
   b) Surgical or other invasive procedure performed on the wrong body part;
   c) Surgical or other invasive procedure performed on the wrong patient;

   For each of a) through c), above, the term "surgical or other invasive procedure" is defined in CMS Medicare guidance on NCDs.
2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as Additional OPPCs.

Patient-Centered Medical Home (PCMH) – a Primary Care practice site that possesses the core competencies of a patient-centered medical home as defined in the Massachusetts Patient-Centered Medical Home Initiative (MA PCMHI) Council

Framework for Design and Implementation
(http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/med-home-framework.pdf).

Performance Incentive – a payment mechanism under which the Contractor may earn payments for meeting targets in the Contract.

Personal Care Attendant (PCA) – a person who provides personal care to a Member who requires assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Personal Care Attendant Services – physical assistance, cueing, and/or supervision with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided to a Member by a PCA in accordance with the Member's Individualized Care Plan.

Personal Care Management (PCM) Agency – a public or private entity under contract with EOHHS to provide Personal Care Management Services.

Personal Care Management (PCM) Services – services provided by a Personal Care Management (PCM) Agency to a participant in accordance with the PCM Contract with EOHHS, including, but not limited to, those services described under 130CMR 422.419(A)**.** PCM Services include, but are not limited to: intake and orientation to instruct a new Consumer in the rules, policies, and procedures of the Self-directed PCA program; assessment of the Member's ability to manage PCA Services independently; development and monitoring of Service Agreements; and provision of functional skills training to assist Consumers in developing the skills and resources to maximize the Consumer's ability to manage their PCA Services.

Poststabilization Care – care related to an Emergency Medical Condition, or Behavioral Health condition, that is provided after an Enrollee is stabilized in order to maintain the stabilized condition or, when covered pursuant to 42 C.F.R. § 438.114(e), to improve or resolve the Enrollee's condition.

Prevalent Languages – a language that is the primary language of 5% or more of ICO service area population.

Primary Care – the provision of coordinated, comprehensive medical services on both a first-contact and a continuous basis to an Enrollee. The provision of Primary Care incorporates an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

Primary Care Provider (PCP) – a practitioner of Primary Care selected by the Enrollee or assigned to the Enrollee by the ICO and responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be nurse practitioners or physicians who are board certified or eligible for certification in one of the following specialties: Family Practice, Internal Medicine, General Practice, OB/GYN, or Geriatrics.

Program of All-Inclusive Care for the Elderly (PACE) – a comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE service area.

Provider – an individual, group, facility, agency, Institution, organization, or business that furnishes or has furnished medical services to Enrollees.

Provider Contract – an agreement between an ICO and a Provider for the provision of services under the Contract.

Provider Network – the collective group of health care and social support Providers, including but not limited to PCPs, nurses, nurse practitioners, physician assistants, specialty Providers, mental health/substance use disorder Providers, community and institutional long-term care Providers, pharmacy Providers, and acute hospital and other Providers employed by or under contract with the ICO.

Provider Preventable Condition – As identified by EOHHS through bulletins or other written statements policy, which may be amended from time to time, a condition that meets the definition of a "Health Care Acquired Condition" or an "Other Provider Preventable Condition" as defined by CMS in federal regulations at 42 C.F.R. 447.26(b).

Quality Improvement Organization (QIO) – a private organization contracted by CMS that monitors the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries.

Rating Categories (RC) – a specific grouping of Enrollees, as described in **Section 7.2**, for which a discrete capitation rate applies.

Reportable Adverse Incident – an occurrence that represents actual or potential serious harm to the well-being of an Enrollee, or to others by the actions of an Enrollee, who is receiving services managed by the Contractor, or has recently been discharged from services managed by the Contractor.

Respondent – the primary organization that submits a response to this Request for Responses (RFR). Respondents must also meet all Medicare requirements established by CMS. (See **Section 1.7**.)

Risk Corridor – a risk-sharing mechanism, as described in **Section 7.5**, in which the State, CMS, and the Contractor share in both earnings and losses under the Contract outside predetermined threshold amount, so that after an initial corridor in which the Contractor is responsible for all losses or retains all earnings, within additional corridors the State and CMS may contribute a portion toward any additional losses and receive a portion of any additional earnings.

Self-direction (for PCA Services) – a model of service delivery in which the Enrollee, or the Enrollee's designated Surrogate, has decision-making authority to hire, manage, schedule, and dismiss their PCA worker(s).

Serious Mental Illness – an individual having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association [APA], 1994) and resulted in functional impairment that substantially interfered with or limited one or more major life activities; and is not based on symptoms primarily caused by substance use, mental retardation or organic disorders.

Service Agreement – a written plan of services developed by the PCM Agency, in conjunction with the Enrollee, or Surrogate, as appropriate, that describes the responsibilities of the PCA, the Enrollee, the Surrogate, the PCM, and the FI as they relate to the management of the Enrollee's Self-directed PCA Services.

Service Area – the specific geographical area of Massachusetts for which an ICO agrees to provide, and is approved to provide Covered Services to all Enrollees who select the ICO.

Subcontractor – an individual or entity that enters into an agreement with the Contractor to fulfill an obligation of the Contractor under this RFR.

Surrogate – the Enrollee's legal guardian, a family member, or other person as identified in the Service Agreement, who is responsible for performing certain PCA management tasks that the Enrollee is unable to perform. The Surrogate must live in proximity to the Consumer and be readily available to perform the PCA tasks as described in the Service Agreement.

Trauma-Informed Care – care, organizations, programs and services that are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization. When a human service program takes the step to become Trauma-Informed, every part of its organization, management and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.

Urgent Care – medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include Primary Care services or services provided to treat an Emergency Medical Condition.

Utilization Management – a process of evaluating and determining coverage for and appropriateness of Covered Services as well as providing needed assistance to clinicians or patients, in cooperation with other parties, to ensure appropriate use of resources,

which can be done on a prospective or retrospective basis, including service authorization and prior authorization.

SECTION 3. PROGRAM DESCRIPTION

Section 3.1 Innovative Features of the Demonstration

CMS and EOHHS seek to add significant value to the current experience of Dual Eligible adults ages 21 through 64 through a number of innovative features of this Demonstration:

- **The ICO provides a fully integrated delivery system with Interdisciplinary Care Teams (ICTs) as the foundation.** ICTs are based in Primary Care practices moving toward becoming Patient-Centered Medical Homes and Health Homes. The ICO is the instrument for integrating Primary Care, Behavioral Health services and community-based supports. The ICO will provide or make available to Enrollees the full range of Covered Services described in **Section 4.2**. The ICO must have internal capacity or make contractual arrangements to ensure the availability of all services in an Enrollee's ICP – including Care Coordinators, IL-LTSS Coordinators (if indicated), specialists, hospitals, and providers of LTSS, home care and other community supports. (See **Section 4.5**.)

- **Global payments to ICOs through Medicare and MassHealth provide ICOs with the flexibility to advance payment and service delivery innovation.** ICOs will be required to demonstrate use of Alternative Payment Methodologies that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. ICOs will have the ability to structure payments to providers to encourage and facilitate care coordination and management, as well as deliver service flexibility that is not possible through current Fee-For-Service structures in Medicare or Medicaid. (See **Section 7**.)

- **A federal/State partnership will contract with ICOs and oversee the Demonstration.** CMS and EOHHS will selectively contract with qualified Respondents to provide the Covered Services described in **Section 4.2**. CMS and EOHHS will develop a single ICO Contract and Contract negotiation process, and will jointly oversee and enforce the ICO Contracts consistent with the desired goal of administrative efficiencies. The ICO selection and contracting processes and timeframes are described in **Sections 11** and **12**.

- **The ICO will have a comprehensive care management system that starts with an individual assessment of each Enrollee and the Enrollee-directed creation of an Interdisciplinary Care Team and Individualized Care Plan.** Enrollees will benefit from active care coordination, and those with more complex needs will be offered more intensive Clinical Care Management. IL-LTSS Coordinators, from Community-Based Organizations expert in working with people with disabilities, will participate on the ICTs of Enrollees who need and/or who are already utilizing LTSS to ensure effective care coordination across the health and human services delivery system and promote continuity of existing LTSS relationships. (See **Sections 4.5** through **4.7**.)

- **The ICO is encouraged to provide services in addition to those available through Medicare and MassHealth Standard (or CommonHealth) on a Fee-For-Service basis.** To meet the diverse needs of Dual Eligible Members, ICOs also will provide expansions of existing MassHealth Standard (or CommonHealth) services, Behavioral Health Diversionary Services currently available only to MassHealth Members enrolled in managed care, and additional Community Support Services. (See **Section 4.2**.)

- **The ICO will have flexibility with service options.** ICOs will be required to include certain services within their benefit plans, and they also will have the flexibility, with the participation of the Enrollee and ICT, to include as part of the ICP other services as alternatives to or means to avoid high-cost traditional services as well as services that best suit the individualized needs and preferences of Enrollees. (See **Section 7.1**.)

Section 3.2 Eligible Populations

Individuals in the State ages 21 through 64 at the time of enrollment who are eligible for MassHealth Standard or MassHealth CommonHealth and who are enrolled in Medicare Parts A and B and eligible for Medicare Part D, and are without other comprehensive public or private insurance, are eligible to enroll in the Demonstration. Enrollees eligible for MassHealth Standard may elect to remain in the Demonstration when they turn 65. Eligible MassHealth Members enrolled in a Medicare Advantage plan or the Program of All-inclusive Care for the Elderly (PACE) may participate in this initiative if they disenroll from their existing programs. MassHealth Members who are enrolled in a HCBS Waiver or are residents of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) may not enroll in the Demonstration initially. EOHHS and CMS reserve the option to include HCBS Waiver participants during the course of this Demonstration.

Section 3.3 Enrollment

A. Enrollment Processes

1. Enrollment in the Demonstration is through a voluntary opt-out process.
2. MassHealth will contact Members who meet the eligibility criteria described in **Section 3.2**, provide them with clear, accessible information about the Demonstration and the ICOs available to them in their county of residence, and inform them of how to enroll in an ICO or to opt out.
3. Members may opt out of the Demonstration or disenroll from an ICO, whether selected or Auto-assigned, at any time, effective at the end of the month.

Any eligible Member who does not communicate his or her choice of either an ICO or to opt out may be assigned to an ICO in their county of residence in a process called Auto-assignment as specified in this section. There will be no Auto-assignment of Members who opt out of the Demonstration. There will also be no Auto-assignment of Members who reside in a county where there is only one participating ICO. ICOs covering a partial county will not receive Auto-assignments in that county. Members enrolled in a Medicare Advantage plan or PACE will not be Auto-assigned

but may participate in the Demonstration if they disenroll from their existing programs. All enrollments will be processed through the MassHealth Key Operations Services Vendor (MassHealth customer service) and communicated to CMS.

The ICO must accept and serve all eligible Members who choose to enroll with the ICO or are Auto-assigned to the ICO. Once a Member is enrolled, the ICO will take steps to maximize continuity of care during the Enrollee's transition to the ICO, as described in **Section 4.8**.

Enrollments are effective on the first calendar day of the month after which they are received and approved. Disenrollments are effective on the first day of the month following the request for disenrollment. The ICO must have a process in place to ensure continuity of services and to cooperate with MassHealth and CMS in the smooth transition of a disenrolled Member either to another ICO or Medicare Advantage plan, to another MassHealth program such as PACE or MassHealth's Senior Care Options Program, or to Fee-For-Service (FFS) MassHealth and traditional Medicare, including Part D plan enrollment.

ICOs must be prepared to accept enrollments effective April 1, 2013, and begin providing coverage for enrolled Members on that date.

Following this start-up period, at various intervals determined by MassHealth, Members who are eligible for the Demonstration and who have neither selected a plan nor opted out of the Demonstration will receive a notice of Auto-assignment to an ICO and an enrollment package that describes their options, including that of opting out of the Demonstration. Members will then have 60 days to select a different ICO or opt out of the Demonstration. MassHealth will proceed with Auto-assignment to the identified ICO for Members who do not make a different choice, with an effective date of the first day of the month following the end of the 60-day period.

Subject to all required federal approvals, in the first year of the Contract, MassHealth anticipates that ICOs will receive Auto-assignments on a rotating basis, except for those counties with only one or no qualified ICO, or to the extent that CMS or MassHealth restricts Auto-assignments. EOHHS will monitor enrollments and Auto-assignments, and may make adjustments to this method if an ICO is does not have sufficient capacity to accept projected auto-assignments. In subsequent years, EOHHS may consider other factors in determining Auto-assignments, such as performance. Notwithstanding the generality of the foregoing, nothing herein shall constitute any obligation on EOHHS, express or implied, to guarantee enrollment into an ICO.

B. Level of Enrollment

Nothing in this RFR shall be construed as an express or implied guarantee of any level of enrollment or number of individuals to be served by an ICO under the Contract.

SECTION 4. SERVICE DELIVERY OBLIGATIONS

Section 4.1 The ICO's Organization

The ICO must be an organization under contract with CMS and EOHHS that will provide an integrated system of care, including Covered Services described in **Appendix C, Tables 1** through **4**. ICOs must comply with all requirements set forth in 42 U.S.C. § 1396u-2 and 42 C.F.R. § 438 et seq., except as set forth in the Contract, and all Medicare Advantage requirements in Part C and Part D of Title XVIII and 42 C.F.R. §§ 422 and 423, except as set forth in the Contract. The ICO will be responsible for providing Enrollees with the full continuum of Medicare and MassHealth Covered Services (described in **Section 4.2**), and for ensuring that care is coordinated and integrated at the point of service through the use of Primary Care Providers, Care Coordinators, Clinical Care Managers, if indicated, and IL-LTSS Coordinators, if indicated. An Interdisciplinary Care Team (ICT) that includes the Primary Care Provider must manage integration and coordination of services. The ICO will be required to ensure compatibility of clinical, administrative, and information systems within ICTs to the extent appropriate, and to develop important linkages across its Provider Network to support delivery of integrated care.

Section 4.2 Covered Services

ICOs will provide a benefit package that includes the comprehensive set of Covered Services listed in **Appendix C, Tables 1** through **4**. Covered Services are available to all Enrollees, as authorized by the Enrollee's ICO. The Covered Services will be managed and coordinated by the ICO through the ICT (see **Section 4.6**).

ICOs must provide the full range of Covered Services. If either Medicare or MassHealth provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the ICO must provide the most expansive set of services required by either program. In other words, ICOs may not limit or deny services to Enrollees based on Medicare or MassHealth providing a more limited range of services than the other program.

Covered Services include:

A. Medicare Part A (inpatient, hospice, home health care), Part B (outpatient) and Part D (pharmacy) services;

B. All MassHealth Standard Fee-For-Service services (including Long-Term Services and Supports (LTSS)), excluding ICF/MR services, targeted case management services, and rehabilitation option services purchased by DMH. (See **Appendix C, Table 1**.)

C. Particular pharmacy products that are covered by MassHealth and may not be covered under Medicare Part D, including:

- Over-the-counter (OTC) drugs as specified at https://masshealthdruglist.ehs.state.ma.us/MHDL/pubdownloadpdfcurrent.do?id=221;

- Barbiturates for indications not covered by Part D (butalbital, mephobarbital, phenobarbital secobarbital);
- "Miscellaneous" drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and
- Prescription vitamins and minerals.

ICOs are encouraged to offer a broader drug formulary than minimum requirements.

D. Behavioral Health Diversionary Services and recovery-based community mental health and substance use disorder services. (See **Appendix C, Table 2**.)

E. Dental Services. Notwithstanding restrictions in MassHealth FFS, dental coverage under the Demonstration will include preventive, restorative, and emergency oral health benefits.

F. Personal Care Assistance, including hands-on assistance with, or cueing and monitoring of, ADLs and IADLs.

G. Durable Medical Equipment (DME), including training in equipment, equipment maintenance and repairs, modifications, and environmental aids and assistive/adaptive technology.

H. Vision Services – the provision of eyeglasses through a contractor of the ICO.

I. Community Support Services, as alternatives to advance wellness, recovery, self-management of chronic conditions, and independent living, and as means to avoid costly acute and long-term institutional services. These services should be tailored to an Enrollee's specific needs and identified in an Enrollee's ICP (see **Appendix C, Table 4** and **Appendix D**).

Section 4.3 Cost-sharing for Covered Services

Except as described below, cost-sharing of any kind is not permitted in this Demonstration.

For all pharmacy products included in the Covered Services described in **Section 4.2**, the ICO may charge co-pays equal to no more than the lower of:

- the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low-Income Subsidy; or
- the applicable MassHealth co-pay amounts.

In addition, ICOs must institute a cap on out-of-pocket pharmacy co-pay expenses for a calendar year consistent with MassHealth policy. In 2012, this cap is $250; this amount may change during the Demonstration. All pharmacy co-pays paid by the Member under the ICO pharmacy benefit will count toward this cap.

ICOs may establish lower cost-sharing for prescription drugs than the maximum allowed.

Section 4.4 Services Not Subject to Prior Approval

Each ICO will assure coverage of Emergency Medical Conditions and Urgent Care services. The ICO must not require prior approval for the following services:

- Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);
- Urgent Care sought outside of the Service Area;
- Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical Provider is unavailable or inaccessible;
- Family planning services; and
- Out-of-area renal dialysis services.

Section 4.5 Network Adequacy

Each ICO will maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services (see **Section 4.2**), including physical, communication and geographic access. ICOs shall execute written contracts with all Providers that include, at a minimum, all provisions required by the Contract.

A. In establishing and maintaining the Provider Network, the ICO must consider the following:

- anticipated enrollment;
- expected utilization of services, taking into consideration the cultural and ethnic diversity, and other demographic characteristics and health care needs of specific MassHealth populations enrolled with the ICO;
- the numbers and types (in terms of training, experience and specialization) of Providers required to furnish Covered Services;
- the number of Network Providers who are not accepting new patients; and
- the geographic location of Providers and Enrollees, considering distance, travel time, and the means of transportation ordinarily used by Enrollees.

B. The ICO must provide each Enrollee with the following within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence:

- at least two PCPs;
- at least two outpatient Behavioral Health Providers;
- two hospitals (when feasible);
- two nursing facilities; and

- two community LTSS Providers per Covered Service as listed in **Appendix C**.

For any Covered Service for which Medicare requires a more rigorous network adequacy standard than described above (including time, distance, and/or minimum number of providers or facilities), the ICO must meet the Medicare requirements.

C. The ICO must meet Personal Care Attendant (PCA) network requirements.

1. Intake and orientation, skills training, development of Service Agreements, and assessment of the Member's ability to manage PCA Services independently:
    a. ICOs must contract with Personal Care Management (PCM) Agencies that are under contract with EOHHS to provide PCM Services to Enrollees accessing Self-directed PCA Services.
    b. Enrollees who are authorized to receive PCA Services at the time of enrollment with the ICO must be granted the option of continuing to receive their PCM Services through their current PCM provider, to ensure continuity of PCA Services.
    c. Enrollees who are not authorized to receive PCA Services at the time of enrollment must be offered a choice of at least two PCM Agencies, at least one of which must be an Independent Living Center (ILC) operating as a PCM where geographically feasible. Enrollees over the age of 60 must be offered the option of receiving PCM Services through an Aging Services Access Point (ASAP) operating as a PCM.
2. Fiscal Intermediary (FI) Services:
    a. Enrollees who are authorized to receive PCA Services at the time of enrollment with the ICO must have the option to continue to receive their FI services through their current FI. Enrollees who are not authorized to receive PCA Services at the time of enrollment with the ICO will elect a PCM Agency. The PCM Agency is responsible for electing a single FI to serve all their Consumers.
3. PCA Evaluations:
    a. ICOs must ensure that PCA evaluations are done in a timely manner to ensure appropriateness and continuity of services.
    b. ICOs may contract with PCM Agencies under contract with EOHHS to perform evaluations for PCA Services.
    c. ICOs that do not contract with ILCs for PCA evaluations must provide and require training for their PCA evaluators on the independent living philosophy.
4. Promoting Self-Direction of Services:
    a. ICOs must provide information, choice and needed supports to promote Self-direction of PCA Services by Enrollees. ICOs must inform Enrollees that they

may identify a Surrogate to help them if they choose Self-directed PCA Services.

b. ICOs must pay for services rendered by the PCA hired by the Enrollee if the PCA meets MassHealth requirements in 130 CMR 422.411 (A)(1) and has completed the required FI paperwork. The ICO must pay the FI the PCA rate as set by the Division of Health Care and Finance Policy under 114.3 CMR 9.00, which includes both the PCA collective bargaining wage, payment for employer required taxes, and workers' compensation insurance.

c. ICOs must contract with FIs under contract with EOHHS to support Enrollees in fulfilling their employer required obligations related to the payment of PCAs.

5. PCA Services for Enrollees who choose not to Self-direct: ICOs must provide Members who choose not to Self-direct, or who are not able to find a Surrogate to assist them to Self-direct, with the option of having their PCA Services provided by an agency. ICOs must contract with such agencies, and provide Enrollees with the choice of at least two PCA agency providers. Services provided by PCA agency providers must be person-centered and the Enrollee must have a choice of the schedule for PCAs and of who provides PCA Services.

D. Each ICO must execute and maintain contracts with the Emergency Service Programs (ESPs – identified in **Appendix G**) that are located within the ICO's Service Area to provide ESP services.

E. ICOs must establish and conduct an ongoing process for enrolling in their Provider Network any willing and qualified Provider that meets the ICO's requirements and with whom mutually acceptable Provider Contract terms, including with respect to rates, are reached.

F. The Provider Network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of the Contract, assure access to all ICO Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the ICO Covered Services;

1. General Provider Credentialing

   The ICO shall implement written policies and procedures that comply with the requirements of 42 C.F.R. § 438.214 regarding the selection, retention and exclusion of Providers and meet, at a minimum, the requirements below in addition to those described in the Contract. The ICO shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually, that all Providers within the ICO's Provider Network are credentialed according to such policies and procedures. The ICO shall:

a. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Providers and all other licensed or certified Providers who participate in the ICO's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards and relevant state regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13;

b. Ensure that all Providers are credentialed prior to becoming Network Providers and that a site visit is conducted with recognized managed care industry standards and relevant state regulations;

c. Maintain a documented re-credentialing process which shall occur regularly, as specified in the Contract, and requires that physician Providers and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards;

d. Upon notice from EOHHS or CMS, not authorize any providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition, if a provider is terminated or suspended from MassHealth, Medicare, or another state's Medicaid program or is the subject of a state or federal licensing action or for any other independent action, the ICO shall terminate, suspend or decline a provider from its Network as appropriate, and notify EOHHS of such action;

e. Not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a Provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. 1001.1801 and 1001.1901;

f. Not establish Provider selection policies and procedures that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;

g. Ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90; and

h. Notify EOHHS and CMS when a Provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information to EOHHS and CMS as required by EOHHS, CMS or state or federal laws, rules, or regulations.

2. Board Certification Requirements

   The ICO shall maintain a policy with respect to Board Certification for PCPs and specialty physicians that ensures that the percentage of board certified PCPs and specialty physicians participating in the Provider Network, at a minimum, is approximately equivalent to the community average for PCPs and specialty physicians in the ICO's Service Area.

3. Laboratory Credentialing

   The ICO shall require all laboratories performing services under this Contract to comply with the Clinical Laboratory Improvement Amendments.

4. As part of the readiness review process prior to contracting, the ICO will be required to document its proposed credentialing/recredentialing and/or licensure requirements and procedures for Providers, by type and service of Provider, and how the ICO will ensure that the minimum credentialing requirements are met by any provider rendering ICO Covered Services, in compliance with this section and **Section 5.9.H**.

Section 4.6 Care Delivery Model

All Covered Services will be provided through a fully integrated delivery system. The

ICO must implement an evidence-based care delivery model, where such evidence-based models exist, that meets the requirements within this section.

A. Primary Care Providers

Each Enrollee will choose or be assigned by the ICO to a Primary Care Provider (PCP). Each ICO must ensure that each Enrollee selects or is assigned a Primary Care Provider within 14 days of the effective date of enrollment. PCPs will:

1. Provide Primary Care;
2. With support of the ICO as needed and as indicated in the Individualized Care Plan developed by the Interdisciplinary Care Team:
   a. For Enrollees without a Behavioral Health diagnosis, provide integrated Behavioral Health services through at least routine screening for depression, substance use disorders, and other Behavioral Health conditions; and
   b. For Enrollees with Behavioral Health conditions, deliver evidence-based behavioral health treatment, and have established protocols for referral to Behavioral Health specialty providers (see **Section 4.6.G** for additional discussion); and

3. With the support of the ICO as needed, designate Care Coordinators to:
    a. Work with Enrollees, families and other key contacts to do initial assessments and ongoing assessments.
    b. Support the Primary Care Provider to assemble and convene Interdisciplinary Care Teams to develop Individualized Care Plans; and
    c. Coordinate the implementation of Individualized Care Plans.

ICOs must provide incentive structures to support Primary Care Providers to accomplish these requirements and to adopt additional medical home and/or Health Home principles and practices.

B. Interdisciplinary Care Team (ICT)

Each Enrollee will have access to an ICT to integrate and coordinate his or her care. The ICO will ensure that care is coordinated within the framework of ICTs and that each ICT member has a defined role appropriate to his or her licensure and relationship with the Enrollee. The Enrollee will be encouraged to identify individuals he or she would like to participate on the ICT.

1. The ICT will consist of at least the following staff:
    a. Primary Care Provider (physician or nurse practitioner);
    b. Behavioral Health clinician, if indicated;
    c. Care Coordinator or Clinical Care Manager, if indicated; and
    d. IL-LTSS Coordinator, if indicated.
2. As appropriate and at the discretion of the Enrollee, the ICT also may include:
    a. Registered nurse;
    b. Physician Assistant;
    c. Specialist clinician;
    d. Other professional and support disciplines including social workers, Community Health Workers, and qualified peers;
    e. Family members;
    f. Other informal caregivers;
    g. Advocates; and
    h. State agency and other case managers.
3. Each ICO will:
    a. Recruit, select, train, manage, and employ or contract with appropriate and qualified personnel, including PCPs, Behavioral Health clinicians, Care Coordinators and IL-LTSS Coordinators, and will maintain staffing levels necessary to perform its responsibilities under the Contract;

b. Ensure that all members of the ICT agree to participate in approved training on the person-centered planning processes, Cultural Competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by EOHHS; and

c. Ensure that the ICT is accessible to the Enrollee and provides alternatives to office visits, including home visits, email and telephone contact.

C. Clinical Care Management

Clinical Care Management is a set of activities provided by a Clinical Care Manager that comprise intensive monitoring, follow-up, and care coordination and clinical management of Enrollees with complex care needs, including but not limited to:

1. Engagement of the Enrollee into Clinical Care Management;
2. Assessment of the clinical risks and needs of each Enrollee;
3. Identification of the Enrollee's strengths, preferences and family and community supports that can assist in addressing the clinical risks;
4. Medication review and reconciliation;
5. Medication adjustment by protocol;
6. Enhanced self-management training and support for complex clinical conditions, including coaching to family members if appropriate;
7. Follow-up within 24 hours of an Enrollee's admission to an acute hospital, and coordination with the Enrollee and hospital staff to facilitate hospital discharges; and
8. Frequent Enrollee contact as appropriate.

ICOs will be encouraged to support Primary Care Providers to offer and deliver Clinical Care Management services at the point of service (e.g., in the Primary Care office setting) where feasible. Where insufficient capacity exists within the Primary Care Provider site, the ICO must support the Primary Care Provider to deliver these services, and must support the development of the capacity at the Primary Care Provider site over the course of the Demonstration to perform these functions.

Accordingly, each ICO (or Primary Care Provider, working in partnership with the ICO as needed) shall determine a mechanism to identify, offer and provide Clinical Care Management services to Enrollees with complex care needs. Such Enrollees may be identified through several mechanisms, including but not limited to analysis of service utilization data, referral by the Primary Care Provider or ICT, and Enrollee self-referral. These Enrollees may include individuals who require multiple prescription medications, have one or more chronic health conditions, or are assessed to be at high-risk of hospital or nursing facility admission, emergency department use, or loss of independence.

D. Independent Living and Long-Term Supports (IL-LTSS) Coordinator

Each ICO will contract with Community-Based Organizations (CBOs) that serve the target population in the ICO's Service Area to employ IL-LTSS Coordinators with expertise in understanding LTSS needs and the resources available in the community to address those needs.

1. Contracting with CBOs

   The ICO will contract with multiple CBOs, including at least one Independent Living Center (ILC), where geographically feasible, in its Service Area for the IL-LTSS Coordinator. Each ICO must contract with an adequate number of CBOs to allow Enrollees a choice of at least two IL-LTSS Coordinators. IL-LTSS Coordinators may have specific knowledge or skills sets to serve certain Enrollees, such as individuals who are Deaf or hard of hearing or individuals with Behavioral Health needs. Additional CBOs may include, but are not limited to, Recovery Learning Communities, ASAPs, and other CBOs serving people with disabilities. Enrollees over the age of 60 must be offered the option of receiving IL-LTSS Coordinator services through an Aging Services Access Point (ASAP).

   The ICO shall not have a direct or indirect financial ownership interest in an entity that serves as a CBO which is contracted to provide IL-LTSS Coordinators. Providers of facility- or community-based LTSS on a compensated basis by the ICO may not function as IL-LTSS Coordinators, except if the ICO obtains a waiver of this requirement from EOHHS. For the purposes of this provision, an organization compensated by the ICO to provide only evaluation, assessment, coordination, skills training, peer supports and Fiscal Intermediary (FI) services is not considered a provider of LTSS.

2. The IL-LTSS Coordinator is responsible for the following activities:

   a. Representing the LTSS needs of the Enrollee, advocating for the Enrollee and providing education on LTSS to the ICT and the Enrollee; providing LTSS coordination that includes assessments and contributing to and/or evaluating the Enrollee's ICP and monitoring the plan at the Enrollee's direction;

   b. As a member of the ICT, participating in initial and ongoing assessments of the health and Functional Status of Enrollees, and developing the community-based component of an ICP necessary to improve or maintain Enrollee health and Functional Status;

   c. Arranging and, with the agreement of the ICT, coordinating the authorization and the provision of appropriate community LTSS and resources;

   d. Assisting Enrollees to access PCA Services;

   e. Monitoring the appropriate provision and functional outcomes of community LTSS, according to the ICP, as deemed appropriate by the ICT;

   f. Determining community-based alternatives to long-term care; and

   g. Assessing appropriateness for facility-based LTSS, if indicated.

3. The IL-LTSS Coordinator will participate as a full member of the ICT, at the discretion of the Enrollee. The IL-LTSS Coordinator shall not be a part of the ICT

if the Enrollee does not have LTSS needs. The ICO must make an IL-LTSS Coordinator available:

a. at any time at the request of the Enrollee with LTSS needs;

b. during the initial assessment;

c. when the need for community-based LTSS is identified by the Enrollee or ICT;

d. if the Enrollee is receiving targeted case management or rehabilitation services purchased by DMH; or

e. in the event of a contemplated admission to a nursing facility, psychiatric hospital, or other Institution.

4. The IL-LTSS Coordinator will assist in identifying a more appropriate IL-LTSS Coordinator if, after initial assessment, it is determined that the Enrollee has specific needs outside the IL-LTSS Coordinator's expertise.

5. The ICO must establish written qualifications for IL-LTSS Coordinators that include, at a minimum:

a. A Bachelor's degree in Social Work or Human Services, or at least two years working in a human service field with the target population;

b. Completion of training that includes education on person-centered planning and person-centered direction;

c. Experience and expertise in working with people with disabilities and/or elders in need of independent living supports and LTSS;

d. Knowledge of the home and community-based service system and how to access and arrange for services;

e. Experience in conducting needs assessments for LTSS needs and with monitoring LTSS delivery;

f. Cultural Competence and the ability to provide informed advocacy;

g. Ability to write an Individualized Care Plan and communicate effectively, verbally and in writing, across complicated service and support systems; and

h. Meets all requirements of their CBO employer.

E. Other Professional and Support Disciplines

Consistent with the Enrollee's ICP, the ICO may employ or contract with Community Health Workers under the supervision of the ICT to provide:

1. Wellness coaching to engage the Enrollee in prevention activities (such as smoking cessation, exercise, diet, obtaining health screenings);

2. Evidence-based practices and techniques for chronic disease self-management;

3. Qualified peer support for Enrollees with mental health and substance use disorders to assist such Enrollees in their recovery, and for Enrollees with

physical disabilities to assist such Enrollees in the pursuit of independent living; and

4. Community supports for newly housed Enrollees who have experienced chronic homelessness.

Community Health Workers must be available and appropriate for the populations served, such as for Enrollees who are Deaf or hard of hearing.

F. Coordinating Services with Federal, State, and Community Agencies

The ICO must coordinate the Enrollee's ICP with services provided by federal, State and community agencies that are not Covered Services based on the Enrollee's preferences and consent to share confidential health information with these supports. Linkages include information sharing and coordinated care efforts. The ICO must develop a systematic process for coordinating care and creating linkages for services for its Enrollees with organizations not providing Covered Services, including but not limited to:

1. State agencies (e.g., the Department of Developmental Services, the Department of Mental Health, the Department of Public Health, Massachusetts Commission for the Blind, Massachusetts Commission for the Deaf and Hard of Hearing, Massachusetts Rehabilitation Commission, and the Executive Office of Elder Affairs);
2. Social service agencies and services (such as housing, food delivery, and nonmedical transportation);
3. Community-based mental health and substance use disorder service programs; and
4. Federal agencies (e.g., the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).

G. Integration and Coordination of Services

This Demonstration aims to promote the integration of Primary Care and Behavioral Health services, and to improve overall integration and coordination of medical, Behavioral Health, and LTSS.

ICOs must promote and support advances in PCPs' and other Providers' capabilities to perform as Patient-Centered Medical Homes and/or Health Homes that provide integrated Primary Care and Behavioral Health care. This may take the form of Behavioral Health services being integrated into a Primary Care setting or vice versa. ICOs must support capacity development in at least the Foundational Elements of Primary Care and Behavioral Health Integration described in **Appendix E**.

With regard to the overall integration and coordination of medical, Behavioral Health and LTSS, beyond supporting Interdisciplinary Care Teams, ICOs may also use qualified peers and non-medical staff (e.g., Community Health Workers) to support and connect Enrollees with community-based resources.

Section 4.7 Assessments and Individualized Care Plan

A. Upon enrollment, and as appropriate thereafter, the ICO will perform in-person comprehensive initial and ongoing assessments using an assessment tool approved by EOHHS.

1. Initial assessments must be completed in-person within 90 days of enrollment for all new Enrollees and recorded in the Centralized Enrollee Record (see **Section 4.10**). ICOs must send certain assessment information completed by a Registered Nurse to MassHealth via MDS-HC application in the Commonwealth's Virtual Gateway to ensure accurate assignment of Rating Categories (see **Section 7.2**). MassHealth will have a robust process for reviewing MDS-HC information submitted by ICOs. ICO must cooperate with and participate in any and all requests made by MassHealth for further information concerning any MDS-HC.
2. Ongoing assessments must be recorded in the Centralized Enrollee Record and performed in-person:
    a. At least annually, or
    b. Whenever an Enrollee experiences a major change that is:
        1) Not temporary;
        2) Impacts more than one area of health status; and
        3) Requires interdisciplinary review or revision of the ICP.

B. The assessment will cover the following domains:

1. Immediate needs and current services;
2. Health conditions and current medications;
3. Functional Status, including what the Enrollee identifies as his/her strengths and interests;
4. Mental health and substance use;
5. Accessibility requirements (including specific communication needs, need for transfer equipment, need for personal assistance, need for appointments at a particular time of day, etc.);
6. Equipment needs including adaptive technology;
7. Transportation access;
8. Housing/home environment;
9. Employment status and interest;
10. Involvement with other care coordinators, care teams, or other State agencies;
11. Informal supports/caregiver supports;
12. Social supports, including cultural and ethnic orientation toward the Enrollee's presenting problems;

13. Food security and nutrition;

14. Wellness and exercise;

15. Advance directives/guardianship; and

16. Personal goals.

In addition, depending on the results of the assessment above, the ICO will perform additional assessment for Enrollees identified as needing intensive Behavioral Health services or LTSS to determine:

1. The Enrollee's understanding of available services;
2. The Enrollee's desire to self-manage all or part of his/her care plan regardless of the severity of disability, and understanding of his or her self-management responsibilities;
3. The Enrollee's preferences regarding privacy, services, caregivers, and daily routine;
4. The Enrollee's understanding of and engagement in recovery-oriented activities;
5. The Enrollee's preferred living situation and a risk assessment for the stability of housing;
5. Risk factors for abuse and neglect in the Enrollee's personal life or finances to ensure safety without compromising the Enrollee's autonomy; and
6. The Enrollee's understanding of his/her rights.

C. Individualized Care Plans (ICP)

The ICO will work with the Enrollee to develop the ICP based on the information gathered from the assessments. The ICO will engage the Enrollee to direct the ICP. The ICP includes:

1. A summary of the Enrollee's health history;
2. A prioritized list of concerns, goals and strengths;
3. The plan for addressing concerns or goals;
4. The person(s) responsible for specific interventions; and
5. The due date for the intervention.

The ICO is responsible for conducting outreach and networking with community-based providers to locate Enrollees who may be homeless or hospitalized, and documenting within the Centralized Enrollee Record its efforts to locate these Enrollees for the purposes of assessment, care planning, and to provide services.

D. Enrollee's Role in Developing the ICP

The Enrollee will be at the center of the care planning process. Each ICP must reflect the Enrollee's preferences and needs. The ICO will ensure that the Enrollee receives

any necessary assistance and accommodations to prepare for and fully participate in the care planning process, and that the Enrollee receives clear information about:

1. His/her health conditions and functional limitations;
2. How family members and social supports can be involved in the care planning as the Enrollee chooses;
3. Self-directed care options and assistance available to self-direct care;
4. Opportunities for educational and vocational activities; and
5. Available treatment options, supports and/or alternative courses of care.

Section 4.8 Continuity of Care

A. The ICO must perform an initial assessment within 90 days of an individual's enrollment in the ICO.

B. ICOs must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

1. a period of up to 90 days, unless the assessment is done sooner and the Enrollee agrees to the shorter time period; or
2. until the ICO completes an initial assessment of service needs, whichever is longer.

C. During the time period set forth in **Section 4.8.B**, the ICO will maintain the Enrollee's current providers at their current provider rates and honor prior authorizations issued by MassHealth, its contracted managed care entities, and Medicare.

D. If, as a result of the initial assessment, the ICO proposes modifications to the Enrollee's prior authorized services, the ICO must provide written notification about and an opportunity to Appeal the proposed modifications no less than 10 days prior to implementation of the Enrollee's ICP. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as set forth in **Section 5.1**.

E. Beyond this time period, the ICO must offer single-case out-of-network agreements to providers who: 1) are not willing to enroll in the ICO Provider Network, 2) are currently serving Enrollees, and 3) are willing to continue serving them at the ICO's in-network rate of payment, under the following circumstances:

1. The ICO's network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in house would require the Enrollee to receive services from multiple Providers/facilities in an uncoordinated manner which could significantly impact the Member's condition;

2. Transitioning the Enrollee to another Provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or
3. Transitioning the Enrollee to another Provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

Section 4.9 Coverage Rules and Service Authorization

A. Medical Necessity

The ICO shall provide services to Enrollees as follows:

1. Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in **Section 4.2**, in accordance with the requirements of the Contract.
2. Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:
   a. Prevent, diagnose, or treat health impairments;
   b. Attain, maintain, or regain functional capacity.
3. Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.
4. Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.
5. The ICO may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The ICO's Medical Necessity guidelines must, at a minimum, be:
   a. Developed with input from practicing physicians in the ICO's Service Area;
   b. Developed in accordance with standards adopted by national accreditation organizations;
   c. Developed in accordance with the definition of Medical Necessity in **Section 2**;
   d. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
   e. Evidence-based, if practicable; and
   f. Applied in a manner that considers the individual health care needs of the Enrollee.
6. The ICO's Medical Necessity guidelines, program specifications and service components for Behavioral Health services must, at a minimum, be submitted to

EOHHS annually for approval no later than 30 days prior to the start of a new Contract Year, and no later than 30 days prior to any change.

7. Offer to MassHealth Enrollees any additional non-medical programs and services available to a majority of the ICO's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by EOHHS and the ICO, such as health club discounts, diet workshops and health seminars. The ICO's capitation rate shall not include the costs of such programs and services.
8. Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the ICO has received EOHHS approval.

B. Authorization of Services

In accordance with 42 C.F.R. § 438.210, the ICO shall authorize services as follows:

1. For the processing of requests for initial and continuing authorizations of Covered Services, the ICO shall:
   a. Have in place and follow written policies and procedures;
   b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and
   c. Consult with the requesting Provider when appropriate.
2. The ICO shall ensure that a physician and a Behavioral Health provider are available 24 hours a day for timely authorization of Medically Necessary services and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's Medical Necessity guidelines must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS.
3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.
4. ICOs shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). ICOs must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and quantitative treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

5. ICOs shall authorize PCA Services to meet Enrollees' needs for assistance with ADLs and IADLs. The ICO may consider the Enrollee's need for physical assistance as well as cueing or monitoring in order for the Enrollee to perform an ADL or IADL. Authorizations must consider the medical and independent living needs of the Enrollee.
6. The ICO must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the ICO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and **Section 5.1**, and must:
    a. Be produced in a manner, format, and language that can be easily understood;
    b. Be made available in Prevalent Languages, upon request; and
    c. Include information, in the most commonly used languages about how to request translation services and Alternative Formats. Alternative Formats shall include materials which can be understood by persons with limited English proficiency.
7. The ICO must make authorization decisions in the following timeframes:
    a. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than 14 calendar days after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:
        1) The Enrollee or the Provider requests an extension, or
        2) The ICO can justify (to EOHHS and/or CMS upon request) that:
            a) The extension is in the Enrollee's interest; and
            b) There is a need for additional information where:
                (i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
                (ii) Such outstanding information is reasonably expected to be received within 14 calendar days.
    b. For expedited service authorization decisions, where the Provider indicates or the ICO determines that following the standard timeframe in subsection **a** could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the ICO must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than three business days after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:
        1) The Enrollee or the Provider requests an extension; or
        2) The ICO can justify (to EOHHS and/or CMS upon request) that:

a) The extension is in the Enrollee's interest; and

b) There is a need for additional information where:

(i) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

(ii) Such outstanding information is reasonably expected to be received within 14 calendar days.

c. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the ICO must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

C. Utilization Management

The ICO shall maintain a Utilization Management plan and procedures consistent with the following:

1. Staffing of all Utilization Management activities shall include, but not be limited to, a Medical Director, or Medical Director's designee. The ICO shall also have a Medical Director's designee for Behavioral Health Utilization Management. All of the team members shall:
   a. Be in compliance with all federal, State, and local professional licensing requirements;
   b. Include representatives from appropriate specialty areas. Such specialty areas shall include, at a minimum, cardiology, epidemiology, OB/GYN, psychiatry, and substance use disorders;
   c. Have at least two or more years of experience in managed care or peer review activities, or both;
   d. Not have had any disciplinary actions or other type of sanction ever taken against them, in any state or territory, by the relevant professional licensing or oversight board or the Medicare and Medicaid programs; and
   e. Not have any legal sanctions relating to his or her professional practice including, but not limited to, malpractice actions resulting in entry of judgment against him or her, unless otherwise agreed to by EOHHS.
2. In addition to the requirements set forth in subsection **1**, the Medical Director's designee for Behavioral Health Utilization Management shall also:
   a. Be board-certified or board-eligible in psychiatry; and
   b. Be available 24 hours per day, seven days a week for consultation and decision-making with the ICO's clinical staff and Providers.
3. The ICO shall have in place policies and procedures that at a minimum:

a. Routinely assess the effectiveness and the efficiency of the Utilization Management program;

b. Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, Behavioral Health treatments, pharmacy formularies and devices;

c. Target areas of suspected inappropriate service utilization;

d. Detect over- and under-utilization;

e. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

f. Compare Enrollee and Provider utilization with norms for comparable individuals and Network Providers;

g. Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services, and out-of-network services, as well as Behavioral Health Inpatient and Outpatient Services, Diversionary Services, and ESPs;

h. Ensure that treatment and Discharge Planning are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other Providers, and other supports identified by the Enrollee as appropriate;

i. Conduct retrospective reviews of the medical records of selected cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care;

j. Refer suspected cases of Provider or Enrollee Fraud or Abuse to EOHHS;

k. Address processes through which the ICO monitors issues around services access and quality identified by the ICO, EOHHS, Enrollees, and Providers, including the tracking of these issues and resolutions over time; and

l. Are communicated, accessible, and understandable to internal and external individuals, and entities, as appropriate.

4. The ICO's Utilization Management activities shall include:

a. Referrals and coordination of Covered Services;

b. Authorization of Covered Services, including modification or denial of requests for such services;

c. Assisting Providers to effectively provide inpatient Discharge Planning;

d. Behavioral Health treatment and Discharge Planning;

e. Monitoring and assuring the appropriate utilization of specialty services, including Behavioral Health services;

f. Providing training and supervision to the ICO's Utilization Management clinical staff and Providers on:

1) The standard application of Medical Necessity criteria and Utilization Management policies and procedures to ensure that staff maintain and improve their clinical skills;

2) Utilization Management policies, practices and data reported to the ICO to ensure that it is standardized across all Providers within the ICO's Provider Network; and

3) The consistent application and implementation of the ICO's clinical criteria and guidelines including the Behavioral Health clinical criteria approved by EOHHS.

g. Monitoring and assessing all ICO services and outcomes measurement, using any standardized clinical outcomes measurement tools to support Utilization Management activities. The ICO's Provider Network contracts shall stipulate that the ICO may access, collect, and analyze such Primary Care, Behavioral Health, and LTSS assessment and outcomes data for quality management and Network Management purposes; and

h. Care management programs.

5. Ensure that clinicians conducting Utilization Management who are coordinating Behavioral Health services, and making Behavioral Health service authorization decisions, have training and experience in the specific area of Behavioral Health service for which they are coordinating and authorizing Behavioral Health services. The ICO shall ensure the following:

   a. That the clinician coordinating and authorizing mental health services shall be a clinician with experience and training in mental health services;

   b. That the clinician coordinating and authorizing substance use disorders shall be a clinician with experience and training in substance use disorders; and

   c. That the clinician coordinating and authorizing services for Enrollees with Co-Occurring Disorders shall have experience and training in Co-Occurring Disorders.

6. The ICO shall have policies and procedures for its approach to retrospective utilization review of Providers. Such approach shall include a system to identify utilization patterns of all Providers by significant data elements and established outlier criteria for all services.

7. The ICO shall have policies and procedures for conducting retrospective and peer reviews of a sample of Providers to ensure that the services furnished by Providers were provided to Enrollees, were appropriate and Medically Necessary, and were authorized and billed in accordance with the ICO's requirements.

8. The ICO shall have policies and procedures for conducting monthly reviews of a random sample of no fewer than 500 Enrollees to ensure that such Enrollees received the services for which Providers billed with respect to such Enrollees.

D. Behavioral Health Service Authorization Policies and Procedures

The ICO shall:

1. Review and update annually, at a minimum, the Behavioral Health clinical criteria and other clinical protocols that the ICO may develop and utilize in its review and submit any modifications to EOHHS annually for review and approval. In its review and update process, the ICO shall consult with its clinical staff or medical consultants outside of the ICO's organization, or both, who are familiar with standards and practices of mental health and substance use treatment in Massachusetts.
2. Review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health services authorization policies and procedures.
3. Develop and maintain Behavioral Health Inpatient Services and Diversionary Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:
    a. If prior authorization is required for any Behavioral Health Inpatient Services admission or Diversionary Service, assure the availability of such prior authorization 24 hours a day, seven days a week;
    b. A plan and a system in place to direct Enrollees to the least intensive but clinically appropriate service;
    c. A system to provide an initial authorization and communicate the initial authorized length of stay to the Enrollee, facility, and attending physician for all Behavioral Health emergency inpatient admissions verbally within 30 minutes, and within two hours for non-emergency inpatient authorization and in writing within 24 hours of admission;
    d. Processes to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed;
    e. A system to concurrently review Behavioral Health Inpatient Services to monitor Medical Necessity for the need for continued stay, and achievement of Behavioral Health Inpatient Services treatment goals;
    f. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans and Diversionary Services treatment plans; and
    g. Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP and other providers, such as community-based mental health services providers, as appropriate;
4. Develop and maintain non- Diversionary Services authorization policies and procedures. Such policies and procedures shall be submitted to EOHHS for review and approval.
5. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

a. Policies and procedures to automatically authorize at least 12 Behavioral Health Outpatient Services;

b. Policies and procedures for the authorization of all Behavioral Health Outpatient Services beyond the initial 12 Outpatient Services;

c. Policies and procedures to authorize Behavioral Health Outpatient Services based upon Behavioral Health clinical criteria; and

d. Policies and procedures based upon Behavioral Health clinical criteria; to review and approve or deny all requests for Behavioral Health Outpatient Services based on clinical criteria.

E. Authorization of LTSS and New Community-Based Services

ICOs must develop an authorization process for LTSS and flexible community-based services that considers the Enrollee's entire Individualized Care Plan (ICP). At a minimum, ICO authorizations of LTSS listed in **Appendix C, Table 1** must comply with MassHealth FFS authorization criteria for those Covered Services. However, the ICO has the discretion to authorize LTSS and flexible community-based services listed in **Appendix C, Table 4** more broadly in terms of criteria, amount, duration and scope, if the ICO determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee as well as cost-effectiveness (the role of the service in preventing higher-cost alternative care such as acute medical or psychiatric hospitalization, institutional long-term care, or emergency department use).

F. Services for Specific Populations

Each ICO shall:

1. At the direction of EOHHS, actively participate in initiatives, processes and activities of EOHHS agencies with which specific Enrollees have an affiliation. Such agencies include, but are not limited to:

   a. The Department of Developmental Services (DSS);

   b. The Department of Mental Health (DMH);

   c. The Department of Public Health and DPH's Bureau of Substance Abuse Services (DPH/BSAS);

   d. The Massachusetts Commission for the Blind (MCB);

   e. The Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH);

   f. The Massachusetts Rehabilitation Commission (MRC); and

   g. The Executive Office of Elder Affairs.

2. Deliver preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or

services as specified in guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.

3. Deliver prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.
4. Provide family planning services as follows:
    a. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services;
    b. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the ICO network; and
    c. Provide all Enrollees who seek family planning services from the ICO with services including, but not limited to:
        1) All methods of contraception, including sterilization, vasectomy, and emergency contraception;
        2) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and
        3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination.
5. Provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing fully integrated delivery system, ICOs shall respect the privacy of Enrollees. ICOs shall comply with **Sections 13.18** and **13.27** regarding compliance with laws and regulations relating to confidentiality and privacy.

G. Emergency and Poststabilization Care Coverage

1. The ICO shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the ICO. The ICO shall pay a non-contracted provider of Emergency and Poststabilization Care an amount equal to or, if the ICO can negotiate a lower payment, less than the amount allowed under MassHealth's Fee-For Service rates, less any payments for indirect costs of medical education and direct costs of graduate medical education. The ICO shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.
2. The ICO shall not deny payment for treatment for an Emergency Medical Condition.

3. The ICO shall not deny payment for treatment of an Emergency Medical Condition if a representative of the ICO instructed the Enrollee to seek Emergency Services.
4. The ICO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
5. The ICO shall require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.
6. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
7. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the ICO if:
    a. Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and
    b. Is a covered benefit under the Contract.

    In Massachusetts, generally accepted principles of professional medical practice for Behavioral Health treatment require the provider of Emergency Services to obtain for the Enrollee an ESP service to receive crisis stabilization treatment and assessment to determine the need for appropriate Poststabilization Care, including Inpatient, Diversionary and Outpatient Services; and
8. The ICO shall cover and pay for Poststabilization Care Services in accordance with 42 C.F.R. § 438.114(e), 42 C.F.R. § 422.113(c), and M.G.L. c. 118E, § 17A.

H. Provider Preventable Conditions

1. In accordance with 42 C.F.R. § 438.6(f)(2), the ICO shall:
    a. As a condition of payment, comply with the requirements mandating Provider identification of Provider-Preventable Conditions, as well as the prohibition against payment for Provider-Preventable Conditions as set forth in 42 C.F.R. § 434.6(a)(12) and 447.26;
    b. Report all identified Provider-Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Section 5.10.C**.
2. In accordance with **Section 4.9.H.1** above, the ICO shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable

Conditions. The ICO's policies and procedures shall also be consistent with the following:

a. The ICO shall not pay a Provider for a Provider Preventable Condition.

b. The ICO shall require, as a condition of payment from the ICO, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or EOHHS.

c. The ICO shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.

d. An ICO may limit reductions in Provider payments to the extent that the following apply:

    1) The identified Provider-Preventable Condition would otherwise result in an increase in payment.

    2) The ICO can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition.

e. The ICO shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services.

Section 4.10 Enrollee Records and Health Information Exchange

While establishing a fully integrated delivery system, ICOs shall respect the privacy of Enrollees. In addition to complying with **Sections 13.18** and **13.27** regarding compliance with law and regulations relating to confidentiality and privacy, ICOs shall share information as requested by Enrollees in writing.

A. Information Network

Each ICO must:

1. Ensure effective linkages of clinical and management information systems among all Providers in the Provider Network (e.g., acute, specialty, Behavioral Health, and LTSS Providers) including clinical Subcontractors by December 2014, leveraging national standards-based statewide Health Information Exchange where applicable; and

2. Maintain a communication network that facilitates coordination of care, including use by the ICT of a single electronic medical record to manage communication and information flow regarding referrals, transitions, and care delivered outside the Primary Care site.

B. Centralized Enrollee Record

Each ICO must maintain a single, comprehensive, Centralized Enrollee Record that documents the Enrollee's medical, functional, and social status. The ICO must ensure that the PCP and all members of the Enrollee's ICT can access the record and make appropriate and timely entries describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed. The Centralized Enrollee Record must contain the following:

1. Enrollee identifying and demographic information (including race, ethnicity, disability type, primary language and homelessness) and family/caregiver contact information;
2. Documentation of each service provided, including the date of service, the name of both the referring Provider and the servicing Provider (if different), and how they may be contacted;
3. Documentation of physical access, and programmatic access needs of the Enrollee, as well as need for accessible medical equipment;
4. Documentation of communication access needs, including live interpreting services, access to telephone devices and advanced technologies that are hearing aid compatible, and video relay service or point-to-point video, for Enrollees who are Deaf or hard of hearing;
5. Documentation of multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate Provider;
6. Laboratory and radiology reports;
7. Prescribed medications, including dosages and any known drug contraindications;
8. Updates on the Enrollee's involvement and participation in community agencies that are not part of the Provider Network, including any services provided;
9. Documentation of contacts with family members and persons giving informal support, if any;
10. Physician orders;
11. Disenrollment agreement, if applicable;
12. Enrollee's individual advance directives and health care proxy, recorded and maintained in a prominent place;
13. Plan for Emergency Medical Conditions and Urgent Care, including identifying information about any emergency contact persons;
14. Emergency psychiatric crisis plans; and
15. Allergies and special dietary needs.

SECTION 5. ADMINISTRATIVE OBLIGATIONS

Section 5.1 Enrollee Grievances and Appeals Processes

A. Enrollee Grievances

An Enrollee Grievance is an Enrollee's written or oral expression of dissatisfaction with any aspect of the operations, activities or behavior of an ICO, or its providers, regardless of whether remedial action is requested. An Enrollee Grievance is different from an Enrollee Appeal, which is described in **Section 5.1.B**.

1. Grievance Filing

   An Enrollee may file an internal Grievance at any time with the ICO or its providers, by calling or writing to the ICO or Provider. An Enrollee also may file an External Grievance at any time by calling or writing to MassHealth. If remedial action is requested, the Enrollee must file the Grievance to the ICO, Provider or MassHealth no later than 60 days after the event or incident triggering the Grievance. The ICO must inform Enrollees of the postal address or toll-free telephone number where an internal or external Enrollee Grievance may be filed.

2. Grievance Administration

   a. Internal Grievance

      The ICO must have a system in place for addressing Enrollee Grievances. The ICO must maintain written Grievance policies and procedures, maintain records of all Grievance activities, and notify MassHealth of all internal Grievances. The system must meet the following standards:

      1) Timely acknowledgement of receipt of each Enrollee Grievance;

      2) Timely review of each Enrollee Grievance;

      3) Response, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than 30 days after the ICO receives the Grievance;

      4) Expedited response, orally or in writing, within 24 hours after the ICO receives the Grievance to each Enrollee Grievance whenever an ICO extends the Appeals timeframe (see **Section 5.1.B.2.b** below) or an ICO refuses to grant a request for an expedited Appeal; and

      5) Availability to Enrollees of information about Enrollee Appeals, as described in **Section 5.1.B**, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

   b. External Grievance

      Enrollees may file written or oral Grievances directly to MassHealth. MassHealth will track all external Grievances and refer to ICOs, as appropriate.

B. Enrollee Appeals

This Demonstration will utilize a coordinated Appeals process that will ensure Enrollees have access to all Medicaid and Medicare Appeals rights. In accordance

with 42 C.F.R. § 422 Subpart M and 42 C.F.R. § 438, an Enrollee may Appeal any ICO decision to deny, terminate, suspend, or reduce services. An Enrollee may also Appeal the ICO's delay in providing or arranging for a Covered Service. A Provider acting on behalf of an Enrollee, and with the Enrollee's written consent, may file an Appeal. The ICO must have written documents prior approved by MassHealth and CMS that notify Enrollees of their rights under this coordinated Appeals process, and procedures that adhere to the following service decision/Appeals process. An Enrollee will continue to receive previously authorized Covered Services until the conclusion of the ICO's Internal Appeals process. Enrollees that pursue further Appeal to the MassHealth Board of Hearings will receive aid pending the BOH decision, upon their timely request.

1. Service Decisions

    a. The ICO must make a decision regarding an Enrollee's request for service within 72 hours of the request for service.

    b. If the ICO decides to terminate, suspend, or reduce a previously authorized Covered Service, the ICO must notify the Enrollee of its decision at least 10 days in advance of the date of its action. As part of its notice obligation, the ICO must send the Enrollee a written notice at the time of its decision. The form and content of the notice must be prior approved by CMS and EOHHS. The written notice must state the reasons for the service termination, suspension or reduction and inform the Enrollee of his/her right to file an Appeal. If a written notice is not received within 10 business days of the service request, the Enrollee may file an internal Appeal.

    c. If the service decision regards a hospital discharge of an Enrollee covered by Medicare, the notice must explain the Quality Improvement Organization (QIO) Appeal process, which is outlined in **Section 5.1.B.4**.

2. Internal Appeals

    a. Filing an Internal Appeal

    If the Enrollee disagrees with the ICO's decision, the Enrollee may file an internal Appeal by writing, faxing, or calling the ICO within 60 calendar days of the receipt of the written denial notice. The Enrollee must follow an oral filing with a written signed Appeal within the 60-day limit. A Provider acting on behalf of an Enrollee, and with the Enrollee's written consent, may file an internal Appeal. The 60-day limit may be extended at the discretion of the ICO. An Enrollee must exhaust the ICO's internal Appeal process under this subsection **2** before the Enrollee can proceed with an external Appeal under subsection **3**.

    b. Making an Internal Appeal Decision

    As specified below, the ICO must make an internal Appeal decision within appropriate timeframes. The ICO must afford a reasonable opportunity for the Enrollee, or a designated representative, to present information orally or in writing during the internal Appeal process. The internal Appeal decision must be made by a physician who was not involved in the initial decision and who

has appropriate expertise in the field of medicine for the services at issue. The ICO must notify the Enrollee of its internal Appeal decision in writing and, for an expedited internal Appeal, the ICO must also make reasonable efforts to provide oral notice.

Standard Internal Appeal Process

- The ICO must notify the Enrollee of the internal Appeal decision as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the ICO's receipt of the Appeal. The ICO may extend this time frame up to 14 calendar days if the Enrollee requests the extension or if the ICO justifies the need for additional information and how the extension of time benefits the Enrollee. When the ICO takes an extension, the Enrollee must be notified in writing.
- If the ICO decides fully in the Enrollee's favor, the ICO must provide or authorize the requested service as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the ICO's receipt of the internal Appeal (or no later than the expiration of an extension).

Expedited Internal Appeal Process

- The Enrollee has the right to request and receive an expedited Appeal decision affecting the Enrollee's medical treatment in a time-sensitive situation. The Enrollee must ask for an expedited 72-hour review when the Appeal request is made.
- If the ICO decides, based on medical criteria, that the Enrollee's situation is time-sensitive or if any physician makes the request for the Enrollee or calls or writes in support of the request for an expedited review, the ICO must issue a decision as expeditiously as the Enrollee's health requires, but no later than 72 hours after receiving the request. The ICO may extend this time frame by up to 14 calendar days if the Enrollee requests the extension or if the ICO justifies the need for additional information and how the extension of time benefits the Enrollee. The ICO must make a decision as expeditiously as the Enrollee's health requires, but no later than the end of any extension period.
- If the ICO determines not to give the Enrollee an expedited Appeal, the ICO must give the Enrollee prompt verbal notice followed by written confirmation within two calendar days that the Appeal will be decided within the time frame for a standard Appeal (30 calendar days).
- If, on expedited Appeal, the ICO decides fully in the Enrollee's favor, the ICO must provide or authorize the requested service as expeditiously as the Enrollee's health condition requires but no later than 72 hours after the ICO's receipt of the Appeal (or no later than upon expiration of an extension discussed above).

3. External Appeals

   As noted, this Demonstration will utilize a coordinated Appeals process that will ensure Enrollees have access to all Medicaid and Medicare Appeals processes. If on internal Appeal the ICO does not decide in the Enrollee's favor, the Enrollee

may Appeal to either the CMS Independent Review Entity (IRE) or the MassHealth Board of Hearings (BOH), or both.

The ICO must automatically forward external Appeals regarding Medicare services to the CMS IRE. An Enrollee may also request a hearing from the MassHealth BOH for an external Appeal regarding Medicare services. For Behavioral Health Diversionary Services, dental services and LTSS, an Enrollee may only appeal to the BOH. An Enrollee using the BOH process may request aid pending Appeal for services that have been prior authorized at the time of filing for the duration of the Appeal process, provided that the Enrollee appeals within 10 calendar days of the date of mailing of the ICO's internal Appeal decision. The ICO will be bound by the IRE or BOH ruling, or subsequent ruling, that is most favorable to the Enrollee.

a. The CMS Independent Review Entity

    1) For standard external Appeals, the CMS Independent Review Entity will send the Enrollee and the ICO a letter with its decision within 30 calendar days after it receives the case from the ICO, or at the end of up to a 14-calendar-day extension.

    2) If the CMS Independent Review Entity decides in the Enrollee's favor and reverses the ICO's decision, the ICO must authorize the service under dispute within 72 hours from the date the ICO receives the review entity's notice reversing the ICO's decision, or provide the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from the date of the notice.

    3) For expedited external Appeals, the CMS Independent Review Entity will send the Enrollee and the ICO a letter with its decision within 72 hours after it receives the case from the ICO, or at the end of up to a 14-calendar-day extension.

    4) If the CMS Independent Review Entity decides in the Enrollee's favor, the ICO must authorize or provide the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the ICO receives the notice reversing the decision.

    5) If the ICO or the Enrollee disagrees with the CMS Independent Review Entity's decision, further levels of Appeal are available, including a hearing before an administrative law judge, a review by the Departmental Appeals Board, and judicial review. The ICO must comply with any requests for information or participation from such further Appeal entities.

b. MassHealth Board of Hearings

    1) Whenever the ICO sends notification to an Enrollee of its service decision, the ICO must include information on filing a BOH Appeal. The form and content of the notification used by the ICO must be prior approved e by EOHHS and CMS.

2) The Enrollee must submit any request for a BOH Appeal, in writing, no later than 30 calendar days from the date of mailing of the ICO's service decision.

3) Whenever an Enrollee submits a written request for a BOH Appeal within 10 calendar days of the date of mailing of the ICO's internal Appeal decision, the ICO is responsible for the continued authorization or provision of any ongoing service in dispute during the pendency of a BOH Appeal.

4) If the BOH decides in the Enrollee's favor, the ICO must authorize or provide the service in dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the ICO receives the notice of the BOH decision.

5) If the ICO or the Enrollee disagrees with the BOH decision, there are further levels of Appeal available, including judicial review of the decision under M.G.L. c. 30A. The ICO must comply with any final decision upon judicial review.

6) The ICO must designate an Appeal Coordinator to act as a liaison between the ICO and BOH.

4. Hospital Discharge Appeals

   a. When an Enrollee is being discharged from the hospital, the ICO must assure that the Enrollee receives a written notice of explanation called a Notice of Discharge and Medicare Appeal Rights (NODMAR).

   b. The Enrollee has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.

   c. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. Note: an Enrollee may file an oral or written request for an expedited 72-hour ICO Appeal if the Enrollee has missed the deadline for requesting the QIO review.

   d. The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.

   e. If the QIO agrees with the ICO's decision, the ICO is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.

   f. If the QIO overturns the ICO's decision, the ICO must pay for the remainder of the hospital stay.

Section 5.2 Customer Service

A. Each ICO will operate an Enrollee services department to assist Enrollees, Enrollees' family members and/or guardians, and prospective Enrollees in learning about and obtaining services from the ICO.

B. Enrollee services departments must:

1. Operate a toll-free Enrollee services telephone line a minimum of nine hours per day during normal business hours, Monday through Friday, with sufficient numbers of Enrollee Services Representatives to answer Enrollee inquiries and respond to Enrollee Grievances and concerns, which shall:
    a. Have at least 90% of calls answered by a trained Enrollee Services Representative (non-recorded voice), within 30 seconds or less; and
    b. Have less than a 5% abandoned call rate;
2. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including American Sign Language (ASL);
3. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;
4. Produce written materials that are:
    a. available in Alternative Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;
    b. in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;
    c. translated into Prevalent Languages; and
    d. mailed with a language card that indicates that the enclosed materials are important and should be translated immediately, and that provides information on how the Enrollee may obtain help with getting the materials translated. This message shall be written in the following languages: Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian, Vietnamese, English, and Spanish;
5. Demonstrate sensitivity to culture, including Disability Culture and the independent living philosophy;
6. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of 4.5 and below, and individualized guidance from Enrollee Services Representatives to ensure materials are understood;
7. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the ICO;

8. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and
9. Ensure that Enrollee Services Representatives make available to Enrollees and potential Enrollees, upon request, information concerning the following:
    a. The identity, locations, qualifications, and availability of Providers;
    b. Enrollees' rights and responsibilities;
    c. The procedures available to an Enrollee and Provider(s) to challenge or Appeal the failure of the ICO to provide a Covered Service and to appeal any Adverse Actions (denials);
    d. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats;
    e. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;
    f. The procedures for an Enrollee to change plans or to opt out of the Demonstration; and
    g. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the ICO.

C. Enrollee Services Representatives (ESRs)

The ICO must employ ESRs who:

1. are trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;
2. are trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;
3. are capable of speaking directly with, or arranging for someone else to speak with, Enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service;
4. are knowledgeable about MassHealth, Medicare, and all terms of the contract, including the Covered Services listed in **Section 4.2**;
5. are available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances.

and who have access to:

6. the ICO's Enrollee database;
7. EOHHS's Eligibility Verification System (EVS); and
8. an electronic Provider directory.

D. Nurse Advice Line

The ICO must maintain a Nurse Advice Line, accessible by Enrollees 24 hours a day, seven days a week. The Nurse Advice Line shall:

1. Be staffed by a registered nurse who shall be available to respond to Enrollee questions about health or medical concerns;
2. Be accessible through a dedicated toll-free telephone number;
3. Provide direct access to a registered nurse for medical triage and health questions, based on industry standard guidelines, to assist Enrollees in determining the most appropriate level of care for their illness or condition;
4. Provide general health information to Enrollees and answer general health and wellness-related questions;
5. Offer an automated health information audio library through which Enrollees can access pre-recorded health education and wellness information on a wide variety of topics applicable to the ICO's MassHealth population;
6. Provide a direct transfer to the ICO's general customer service center for non-clinical administrative questions during the ICO's hours of operation, and to the ICO's Behavioral Health clinical question telephone line for clinical Behavioral Health questions during the ICO's hours of operation;
7. Offer all services in both English and Spanish, at a minimum;
8. Make oral interpretation services available free-of-charge to Members and Enrollees in all non-English languages spoken by Members and Enrollees;
9. Maintain the availability of services, such as TTY services or comparable services for the Deaf and hard of hearing; and
10. Provide coordination with the Enrollee's Care Coordinator and PCP, when appropriate, based on protocols established by the ICO and incorporated into the subcontractual arrangement with the Nurse Advice Line subcontractor, if any.

E. Obligation to Assist Enrollees to Report Demographic Changes to MassHealth

With Enrollee consent, assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page Application on the Virtual Gateway or via other information exchange processes established with MassHealth, as follows:

1. If the ICO learns from an Enrollee or an Eligibility Representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the ICO obtains demographic information from the Enrollee or the Enrollee's Eligibility Representative, the ICO shall provide such information to EOHHS, after obtaining the Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

2. Prior to entering such demographic information, the ICO shall advise the Enrollee as follows: "Thank you for this change of address [phone] information. You are required to provide updated address [phone] information to MassHealth. We would like to help you to do that so, with your oral permission, we will forward this information to MassHealth. You may also provide MassHealth with information about your race or ethnicity. This is not required, but it will help MassHealth to improve Member services. You have provided us with this information. If you do not object, we will pass that information on to MassHealth for you."
3. If the ICO receives updated demographic information from a third party, such as a Provider, a vendor hired to obtain demographic information, or through the post office, the ICO must confirm the new demographic information with the Enrollee and obtain the Enrollee's permission, prior to submitting the information to EOHHS.
4. The ICO shall ensure that all appropriate staff transmitting this information have submitted the necessary documentation and completed any necessary training to perform this function, including but not limited to training on EOHHS systems.

Section 5.3 Outreach and Enrollee Materials

A. Requirements for Outreach and Enrollee Materials

The ICO must:

1. Submit to EOHHS and CMS outreach and Enrollee materials and phone scripts, including non-English Outreach materials along with an English translation, an attestation from a certified translation agency, and a signature of the ICO Director, for review and approval, in accordance with CMS and EOHHS requirements to be specified in the Contract. Such materials include, but are not limited to:
    a. Outreach and education materials;
    b. Orientation materials;
    c. Benefit coverage information; and
    d. Operational letters for enrollment, disenrollment, claims, service denials, Grievances, Appeals, and Provider terminations.
2. Ensure that all information provided to Enrollees and potential Enrollees (and families, when appropriate) is provided in a manner and format that is easily understood and that is:
    a. In print that is at least 12 point font, including any footnotes and subscript annotations;
    b. Available in the Prevalent Languages used in the Service Area;
    c. Distributed throughout the entire Service Area;
    d. Written with sensitivity to literacy level, culture, and disability;

e. Available in Alternative Formats, according to the needs of Enrollees and potential Enrollees, or persons assisting actual or potential Enrollees, including Braille, large print (at least 16 point font),oral interpretation services in non-English languages, audiotape, American Sign Language video clips, and other alternative media, as requested;

3. Ensure that all pre-enrollment and disenrollment materials include a statement that the ICO's plan is a voluntary MassHealth benefit in association with EOHHS and CMS;

4. Make the following information available upon the request of an Enrollee or potential Enrollee, including but not limited to:

   a. A clear, comprehensive description of the ICO's plan;

   b. Detailed information about the Covered Services, and the procedures for obtaining such benefits, including authorization requirements;

   c. A description of the options Enrollees and Potential Enrollees have to enroll, disenroll, and transfer on a monthly basis;

   d. A directory of all Providers in the ICO's Provider Network. The ICO shall:

      1) Develop and make available a Network Provider Directory that identifies the ICO's Network Providers, including, at a minimum, physicians, hospitals, and pharmacies. The directory shall include the following information:

         a) Network Providers with areas of special experience, skills and training, including Providers with expertise in treating:

            - persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with Serious Mental Illness;
            - Homeless persons;
            - persons with Co-Occurring Disorders; and
            - other specialties;

         b) office addresses and telephone numbers for each Network Provider;

         c) office hours for each Network Provider, including the names of any Network Provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

         d) the cultural and linguistic capabilities of Network Providers, including languages spoken by the Network Provider or by skilled medical interpreter at the Network Provider's site;

         e) Network Provider licensing information;

         f) whether the Network Provider is accessible for people with physical disabilities; and

         g) Network Provider access by public transportation.

2) Maintain an up-to-date version of the Network Provider Directory on the ICO's website that is available to the general public. The web version of the Network Provider Directory should include the capability to search by:

   a) Name;

   b) Town;

   c) ZIP code;

   d) Provider specialty;

   e) languages spoken; and

   f) Provider licensing information.

3) Within a reasonable time after enrollment, provide each Enrollee with a postcard notification that a copy of the Network Provider Directory can be accessed online at the ICO's website, or available in writing by calling the Enrollee Services department;

4) Provide written notice to Enrollees of any changes in the Network Provider directory at least 30 days before the intended effective date of the change or as soon as the ICO becomes aware of such change;

5) In the event of the termination of a Network Provider, provide written notice within 15 days after receipt or issuance of the termination notice to each Enrollee who was seen within the previous 90 days by the terminated Provider, and ensure that care is transferred to another Network Provider in a timely manner to minimize any disruptions to treatment;

6) Provide annual notification to Providers, Enrollees and other interested parties that the most current version of the Network Provider Directory is available on the ICO's website and that hard copies are available on request;

e. Information on the Enrollee's right to file a Grievance or Appeal;

f. Information on the process of accessing primary and specialty care, including Urgent Care and Emergency Medical Conditions; and

g. The name and customer services telephone number for all Material Subcontractors that provide Covered Services to Enrollees, unless the ICO retains all customer services functions for all Covered Services.

B. Optional Outreach Activities

The ICO <u>may</u>:

1. Post written outreach and promotional materials approved by CMS and EOHHS at ICO Provider Network locations and other sites throughout the Service Area of the ICO;

2. Use television, radio, printed media, including free newspapers, and website postings, for the purpose of outreach or promotion in accordance with the requirements set forth in the Contract;
3. Distribute approved outreach and promotional materials by mail to potential Enrollees throughout the ICO's Service Area;
4. Provide non-financial promotional items only if they are offered to everyone who attend a health fair or community sponsored event, regardless of whether or not they enroll with the ICO, and only if the items are of a retail value of $10 or less; and
5. Conduct nursing facility visits and home visits for interested individuals only if the ICO has documented a request to visit by an individual or a person recognized under CMS and MassHealth requirements to make this request on behalf of an individual.

C. Prohibited Outreach Activities

The ICO may <u>not</u>:

1. Offer financial or other incentives to induce Consumers to enroll with the ICO or to refer a friend, neighbor, or other person to enroll with the ICO;
2. Directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;
3. Distribute any material that has not been pre-approved by EOHHS and CMS;
4. Distribute any material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the material, including but not limited to any assertion or statement, whether written or oral, that:
    a. The recipient of the material must enroll in the ICO's Plan in order to obtain benefits or in order to not lose benefits; or
    b. The ICO is endorsed by CMS, Medicare, the federal or state government or similar entity.
5. Seek to influence a Member's enrollment in the ICO's Plan in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance);
6. Engage in any outreach activities which could mislead, confuse or defraud Members or Enrollees, or misrepresent MassHealth, EOHHS, the ICO or CMS;
7. Incorporate any costs associated with marketing or marketing incentives or non-medical programs or services in the report specified in the Contract; or
8. Engage in outreach activities which target Members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

D. Eligibility Redetermination Assistance

The ICO or Provider staff may help Enrollees complete eligibility redetermination activities in the following ways. Such staff may:

1. Explain the MassHealth Eligibility Redetermination Verification (ERV) forms to applicants;
2. Offer to assist Enrollees with completion of the annual ERV form; and
3. Refer MassHealth applicants to the MassHealth Customer Service Center.

Section 5.4 ADA Compliance

Each ICO and its Providers must comply with the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. ICOs and their Providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility.

The ICO must reasonably accommodate persons and shall ensure that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the ICO by:

A. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

B. Providing interpreters or translators for Enrollees who are Deaf and hard of hearing and those who do not speak English;

C. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

1. Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;
2. Ensuring that all written materials are available in formats compatible with optical recognition software;
3. Reading notices and other written materials to individuals upon request;
4. Assisting individuals in filling out forms over the telephone;
5. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;
6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf; and

7. Individualized assistance.

D. Ensuring safe and appropriate physical access to buildings, services and equipment.

The ICO must identify to EOHHS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The ICO must also establish and execute a work plan to achieve and maintain ADA compliance.

Section 5.5 Consumer Input

The ICO must obtain Consumer and community input on issues of program management and Enrollee care through a range of approaches. The ICO must also establish at least one Consumer advisory committee and a process for that committee to provide input to the governing board. The ICO must also demonstrate participation of Consumers with disabilities, including Enrollees, within the governance structure of the ICO.

Section 5.6 Learning Collaboratives

The Commonwealth expects to convene learning opportunities for ICO staff and providers. Sessions may be convened on topics including but not limited to: the independent living philosophy, the recovery philosophy, accessibility and the ADA, diversionary behavioral health services, community support services, and serving chronically homeless Enrollees. The ICO must make available key ICO staff and contracted provider staff as appropriate to attend these learning opportunities.

Section 5.7 Quality Monitoring

ICOs will collect and report to MassHealth quality and cost measures in seven domains: access and availability, care coordination, health and well-being, mental and Behavioral Health, patient/caregiver experience, screening and prevention, and quality of life. The domains and potential key proposed measures are described below. Sources include the Consumer Assessment of Healthcare Providers and Services (CAHPS) surveys, HEDIS, and the Prevention Quality Indicators (PQI). The specific quality metrics will be identified in the final Contracts. Performance Incentives for quality and cost savings are described in **Section 7.6**. The State and CMS shall coordinate ICO external quality reviews conducted by the Quality Improvement Organization (QIO) and External Quality Review Organization (EQRO).

A. DOMAIN: Access and Availability

1. CAHPS: Being examined on the examination table (NQF #7)
2. CAHPS: Access to specialists (NQF #5)
3. CAHPS: Getting timely care, appointments and information (NQF #5)
4. CAHPS: Access to transportation (NQF #7)
5. HEDIS: Frequency of Ongoing Prenatal Care (NQF #1391)

B. DOMAIN: Care Coordination

1. Three-item Care Transition Measure (NQF #228)
2. Ability to use health information technology to perform care management at point of care (NQF #490)
3. CAHPS: Coordination of care (NQF #7)
4. CAHPS: Shared decision-making (NQF #5)
5. CAHPS: Health promotion and education (NQF #7)
6. CAHPS: Integration of care (NQF #5)
7. Plan all-cause readmission (NQF #0329)
8. PQI 05: Chronic obstructive pulmonary disease admission rate (NQF #275)
9. PQI 08: Congestive heart failure admission rate (NQF #277)
10. Reconciled medication list (NQF #97)
11. Timely transmission of transition record (NQF #648)
12. Transition record with data elements received (NQF #647)

C. DOMAIN: Health and Well-Being

1. ACE Inhibitor or ARB for left ventricular dysfunction (NQF #81)
2. Annual monitoring for patients on persistent medications (NQF #21)
3. Avoidance of antibiotic treatment in adults with acute bronchitis (NQF #58)
4. CAHPS: Health status/Functional Status (NQF #6)
5. Comprehensive diabetes care (NQF #0731)
6. Evaluation of left ventricular systolic function (NQF #135)
7. Controlling high blood pressure (NQF #18)
8. Ischemic vascular disease: blood pressure management control (NQF #73)
9. Pain assessment conducted (NQF #523)
10. HEDIS: Use of appropriate medications for people with asthma (NQF #36)

D. DOMAIN: Mental and Behavioral Health

1. HEDIS: Antidepressant medication management (NQF #105)
2. Follow-up after hospitalization for mental illness (NQF #576)
3. Initiation and engagement of alcohol and other drug dependence treatment (NQF #4)
4. Screening for clinical depression and follow-up plan (NQF #418)
5. Unhealthy alcohol use: screening and brief counseling

E. DOMAIN: Patient/Caregiver Experience

1. CAHPS: Communication quality (NQF #5)
2. CAHPS: Patients' rating of doctor (NQF #5)
3. CAHPS: Knowledge of patient (NQF #5)
4. HCAHPS: 27-items survey instrument with 7 domain-level composites including: communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, cleanliness and quiet of the hospital environment, and discharge information (NQF #166)

F. DOMAIN: Patient/Caregiver Experience

1. CAHPS: Communication quality (NQF #5)
2. CAHPS: Patients' rating of doctor (NQF #5)
3. CAHPS: Knowledge of patient (NQF #5)
4. HCAHPS: Hospital experience information including communication with doctors and nurses, responsiveness of staff, pain control, hospital environment, and discharge information (NQF #166)

G. DOMAIN: Screening and Prevention

1. Adult weight screening and follow-up (NQF #421)
2. CAHPS: Health promotion and education (NQF #5)
3. HEDIS: Cervical cancer screening (NQF #32)
4. Screening for fall risk (NQF #101)
5. Influenza immunization (NQF #41)
6. HEDIS: Mammography screening (NQF #31)
7. HEDIS: Prenatal and postpartum care (NQF #1517)
8. Tobacco use assessment and tobacco cessation intervention (NQF #28)

H. DOMAIN: Quality of Life

ICOs will conduct a Quality of Life survey that assesses the outcomes of appropriate and sufficient integrated care. EOHHS will determine or develop the survey tools and may require other measures of quality of life.

Section 5.8 Financial Requirements

The ICO must comply with, and demonstrate to the satisfaction of EOHHS that it meets, all financial requirements as determined by EOHHS and CMS. The financial information below must be submitted at least annually, and at other times as EOHHS might request.

A. Minimum Net Worth

The ICO must demonstrate and maintain minimum net worth as specified below. For the purposes of the Contract, minimum net worth is defined as assets minus liabilities.

1. Throughout the term of the Contract, the ICO must maintain a minimum net worth of $1,500,000, subject to the following conditions:
    a. A minimum of $1,200,000 of this requirement must be in cash;
    b. The ICO may include 100% of the book value (the depreciated value according to generally accepted accounting principles (GAAP) of tangible health care delivery assets carried on its balance sheet;
    c. If at least $1,200,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 20% of the minimum net worth required will be allowed; and
    d. If less than $1,200,000 of the minimum net worth requirement is met by cash, then the GAAP value of intangible assets up to 10% of the minimum net worth required will be allowed.

B. Working Capital Requirements

The ICO must demonstrate and maintain working capital as specified below. For the purposes of the Contract, working capital is defined as current assets minus current liabilities. Throughout the terms of the Contract, the ICO must maintain a positive working capital, subject to the following conditions:

1. If an ICO's working capital falls below zero, the ICO must immediately notify EOHHS and submit a written plan within 30 days, certified by an independent auditor, to reestablish a positive working capital balance for approval by EOHHS.
2. EOHHS may take any action they deem appropriate, including termination of the Contract, if the ICO:
    a. Fails to report a negative working capital balance that is subsequently identified through an audit;
    b. Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time as determined by EOHHS;
    c. Violates a corrective plan approved by EOHHS; or
    d. EOHHS determines that negative working capital cannot be corrected within a reasonable amount of time as determined by EOHHS.

C. Financial Stability

1. Financial Stability Plan

    Throughout the term of the Contract, the ICO must:

    a. Remain financially stable;

b. Maintain adequate protection against insolvency in an amount determined by EOHHS, as follows:

1) Provide to Enrollees all Covered Services required by the Contract for a period of at least 45 calendar days following the date of insolvency or until written approval to cease providing such services is received from EOHHS, whichever comes sooner;

2) Continue to provide all such services to Enrollees who are receiving inpatient services at the date of insolvency until the date of their discharge or written approval to cease providing such services is received from EOHHS, whichever comes sooner; and

3) Guarantee that Enrollees and EOHHS do not incur liability for payment of any expense that is the legal obligation of the ICO, any of its Subcontractors, or other entities that have provided services to Enrollees at the direction of the ICO or its Subcontractors;

c. Immediately notify EOHHS when the ICO has reason to consider insolvency or otherwise has reason to believe it or any Subcontractors is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the ICO's board of the potential for insolvency; and

d. Maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any Provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance.

2. Insolvency Reserve

a. The Insolvency Reserve shall be defined as the funding resources available to meet costs of providing services to Enrollees for a period of 45 days in the event that the ICO is determined insolvent. Funding the Insolvency Reserve shall be the sole responsibility of the ICO, regardless of any risk sharing arrangements with EOHHS or CMS.

b. EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the ICO within 45 days of the start of the Contract Year.

c. The Insolvency Reserve calculation shall be an amount equal to 45 days of the ICO's estimated medical expenses, not to exceed 88% of the calculated value of 45 days of capitation payment revenue.

d. Within 30 calendar days of receipt of the Insolvency Reserve calculation, the ICO must submit to EOHHS written documentation of its ability to satisfy EOHHS' Insolvency Reserve Requirement. The documentation must be signed and certified by the ICO's chief financial officer.

e. Subject to EOHHS' approval, the ICO may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; performance guarantee as specified in **Section 5.8.C.3**; insolvency

insurance or reinsurance, performance bonds; irrevocable letter of credit; and other letters of credit or admitted assets as specified in **Appendix F**

3. Performance Guarantees and Additional Security

   Throughout the term of the Contract, the ICO must provide EOHHS with performance guarantees that are subject to prior review and approval from EOHHS. Performance guarantees must include:

   a. A promissory note from the ICO's parent(s) or a performance bond from an independent agent in the amount of $1,500,000 to guarantee performance of the ICO's obligation to provide Covered Services in the event of the ICO's impending or actual insolvency; and

   b. A promissory note from the ICO's parent(s) or a performance bond from an independent agent in the amount of $600,000 to guarantee performance of the ICO's obligations to perform activities related to the administration of the Contract in the event of the ICO's impending or actual insolvency.

D. Medical Loss Ratios (MLR)

At the end of each Contract Year, the ICO shall provide to EOHHS an audited statement of its medical loss ratio for the past year within 90 days.

E. Other Financial Requirements

1. Auditing and Financial Changes

   The ICO must:

   a. Ensure that an independent financial audit of the ICO is performed annually. This audit must comply with the following requirements:

      1) Provide EOHHS with the ICO's most recent audited financial statements; and

      2) Provide an independent auditor's report on the processing of the transactions using the American Institute of Certified Public Accountants (AICPA) Statement on Auditing Standards SAS 70 protocol and Chapter 647 of the Acts of 1989 (also known as the Internal Control Law);

   b. Report quarterly, or more frequently if requested by EOHHS, on any significant deficiencies in internal controls as follows.

      Each ICO shall:

      1) Furnish EOHHS with a written report prepared by the independent auditor that provided the ICO's independent financial audit describing significant deficiencies in the ICO's internal control structure noted by the accountant during the audit. No report need be issued if the accountant does not identify significant deficiencies.

2) Describe in writing the remedial actions it has taken or proposes to take to correct significant deficiencies, if such actions are not described in the accountant's report. EOHHS may require the ICO to take additional or different corrective action to correct such deficiencies.

c. Notification of Adverse Financial Condition. ICOs shall require the independent certified public accountant to immediately notify in writing an officer and all members of its Board of Directors of any determination by the independent certified public accountant that the ICO has materially misstated its financial condition as reported to EOHHS for the fiscal year ended immediately preceding. The ICO shall furnish such notification to EOHHS within five days of receipt thereof. If the accountant, subsequent to the date of the audited financial report becomes aware of facts which would have affected his or her report, EOHHS notes the obligation of the accountant to take such action as prescribed by Section 561 of the Statement of Auditing Standards Number One of the American Institute of Certified Public Accountants.

d. Submit on an annual basis after each annual audit a representation letter signed by the ICO's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed;

e. Utilize a methodology approved by EOHHS to estimate incurred but not reported (IBNR) claims adjustments;

f. Immediately notify EOHHS of any material negative change in the ICO's financial status that could render the ICO unable to comply with any requirement of the Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency;

g. Notify EOHHS in writing of any default of its obligations under the Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the ICO's ability to satisfy its payment or performance obligations under the Contract;

h. Advise EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new contracts, or business ventures being contemplated by the ICO that may negatively impact the ICO's ability to perform under this RFR or the Contract; and

i. Refrain from investing funds in, or loaning funds to, any organization in which a director or principal officer of the ICO has an interest.

2. Risk Arrangements

The ICO may maintain Provider risk arrangements. The ICO must disclose these arrangements to EOHHS as follows.

a. The ICO must provide a description of any changes in its risk arrangements with all members of its Provider Network, including, but not limited to,

Primary Care, specialists, hospitals, nursing facilities, other long-term care Providers, Behavioral Health Providers, and ancillary services.

b. Any incentive arrangements must not include any specific payment as an inducement to withhold, limit, or reduce services to Enrollees.

c. The ICO must monitor such arrangements, in accordance with the standards of EOHHS and CMS for quality of care, to ensure that medically appropriate Covered Services are not withheld.

d. Right to Audit and Inspect Books. The ICO must grant EOHHS or any authorized state or federal authority including, but not limited to, CMS, the state or federal Office of the Inspector General, and the State Auditor, the right to at any time audit and inspect its books and records. The ICO must cooperate fully in any such audit or inspection.

   EOHHS or other authorized authority, shall determine the nature, scope and frequency of examinations. Such examinations may cover all aspects of the ICO's assets, condition, affairs and operations including the ICO's capacity to bear the risk of potential financial losses or services performed or the determination of amounts payable under the Contract. Examinations may also include and be supplemented by audit procedures performed by independent certified public accountants as herein provided.

   The type of examinations performed by EOHHS' examiners may include, but shall not be limited to, the following:

   1) Financial surveillance, which will consist of a review of the audited financial report and annual statement and may include a review of the independent certified public accountant's working papers if expressly required and a general review of the ICO's corporate affairs and operations to determine compliance with Massachusetts General Laws, the Rules and Regulations of EOHHS, and the terms of the ICO contract. The examiners may perform alternative or additional examination procedures to supplement those performed by the independent certified public accountants when the examiners determine that such procedures are necessary to verify the financial condition of the ICO;

   2) Targeted examinations, which will cover specific areas of an ICO's operations as EOHHS may deem appropriate; and

   3) Comprehensive examinations, as determined necessary by EOHHS. Such examinations may be conducted by EOHHS or its appointed agent.

   EOHHS' costs for work performed by independent certified public accountants shall be borne by the ICO and may be deducted from the ICO's capitation payment.

e. The ICO must provide EOHHS with any other information that EOHHS deems necessary to adequately monitor and evaluate the financial strength of the ICO or that must be provided to EOHHS by law.

3. Reporting

   The ICO must submit to EOHHS all required financial reports, as described in the Contract, in accordance with specified timetables, definitions, formats, assumptions, and certifications as well as any ad hoc financial reports required by EOHHS at a frequency determined by EOHHS.

4. Financial Responsibility for Post-Stabilization Services

The ICO must pay for Poststabilization Care in accordance with 42 C.F.R. § 438.114e

Section 5.9 Contract Management

The ICO shall:

A. Maintain all Provider Contracts and other agreements and subcontracts relating to this Contract in writing. All such agreements and subcontracts shall fulfill all applicable requirements of 42 C.F.R. § 438, and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity. Without limiting the generality of the foregoing, the ICO shall ensure that all Provider Contracts include the following provision: "*Providers shall not seek or accept payment from any Enrollee for any Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any Covered Service rendered to an Enrollee. Instead, Providers shall look solely to the [ICO's name] for payment with respect to Covered Services rendered to Enrollees. Furthermore, Providers shall not maintain any action at law or in equity against any Enrollee or EOHHS to collect any sums that are owed by the [ICO's name] under the Contract for any reason, even in the event that the [ICO's name] fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where "Contract" refers to the agreement between the Contractor and any Network Providers and non-Network Providers).*" The Provider Contracts shall further state that this requirement shall survive the termination of the Contract for services rendered prior to the termination of the Contract, regardless of the cause of the termination;

B. Ensure its Provider Contracts specify that:

1. No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition; and
2. Require, as a condition of payment from the ICO, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or EOHHS;

C. Actively monitor the quality of care provided to Enrollees under any Provider Contracts and any other subcontracts;

D. Remain fully responsible for meeting all of the terms and requirements (including all applicable state and federal regulations) of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No

subcontract will operate to relieve the ICO of its legal responsibilities under the Contract;

E. Monitor and ensure that all Utilization Management activities provided by a Material Subcontractor comply with all provisions of this Contract;

F. Ensure that all Provider Contracts prohibit Providers from billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments. Such Provider Contracts shall require Providers to work with Enrollees and the ICO to assist Enrollees in keeping their appointments; and

G. Ensure that Provider Contracts prohibit Providers from refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a Member.

H. Ensure that that its Provider Contracts specify that the Provider must comply with the ICO's requirements and meet industry standards for credentialing and recredentialing.

Section 5.10 State and Federal Reporting Requirements

A. Quality Measures

ICOs will be required to report HEDIS, HOS and CAHPS data, including SNP-level HEDIS measures. Additionally, all ICOs will be required to report standard quality measures as specified in the Contract, as well as to participate in capturing data for and reporting metrics to be developed to measure quality of long-term services and supports. Other reporting requirements may be specified in the three-way Contract between CMS, EOHHS and the ICO.

A core set of these measures will be used for the purposes of assessing plan performance and outcomes, as well as for calculating the quality withhold payment as specified in **Section 7.6**. CMS will work closely with the State to monitor other measures related to community integration. CMS and the State may refine and update these quality measures in Years 2 and 3 of the Demonstration.

B. Encounter Data

ICOs will be required to:

1. Collect and maintain 100% encounter data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data;
2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the ICO's collection and maintenance of encounter data;
3. Upon request by EOHHS, or its designee, provide medical records of Enrollees and a report from administrative databases of the encounters of such Enrollees in

order to conduct validation assessments. Such validation assessments may be conducted annually;

4. Produce encounter data according to the specifications, format, and mode of transfer reasonably established by EOHHS, or its designee, in consultation with the ICO. Such encounter data will include, but is not limited to, the data elements described in **Appendix H**. Changes to this specification are being developed to account for the Covered Services (e.g., LTSS) not previously applicable to managed care;
5. Provide encounter data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the ICO;
6. Submit encounter data that is at a minimum 99% complete and 95% accurate. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the ICO must have systems in place to monitor and audit claims. The ICO must also correct and resubmit rejected encounters as necessary. The data shall be considered complete and accurate if the error rate in the initial submission is no more than 3% and the number of encounters that need to be manually overridden is no more than 1%; and
7. Submit additional data files related to the Demonstration as needed.

C. Provider Preventable Conditions

Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), the Contractor shall comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS.

SECTION 6. DEMOGRAPHIC, UTILIZATION AND FINANCIAL DATA FOR USE BY RESPONDENTS

A Data Book is available for the purpose of assisting Respondents in preparing response submissions. Please see the files posted on Comm-PASS, named "Data Book - Phase 1 - Medicare Parts AB and Medicaid.xlsx" and "Data Book - Phase 1 - Medicare Part D.zip."

SECTION 7. GENERAL PAYMENT PRINCIPLES

Section 7.1 General Approach

EOHHS and CMS seek to create a payment model that:

- holds ICOs accountable for the comprehensive care they integrate, coordinate and deliver;
- promotes development of comprehensive Primary Care models, such as Patient-Centered Medical Homes and Health Homes;
- rewards quality of care and improved outcomes;
- encourages service delivery innovation and flexibility; and

- reduces health care spending.

The ICO will receive an actuarially developed, prospective monthly Global Payment for each ICO Enrollee for the full continuum of benefits the ICO provides to its Enrollees. Medicare and Medicaid will provide separate capitation payments that contribute to the total base global rate for the range of Covered Services, but these contributions will not be directly aligned with payment for particular services (e.g., Medicare will not pay solely for Medicare services and Medicaid will not pay solely for Medicaid services).

Within this Global Payment structure, the ICO will be required to provide all of the Covered Services listed in **Appendix C, Tables 1** through **3.** ICOs also will have the flexibility to provide a range of other community support services as listed in **Appendix C, Table 4**, as identified by the Enrollee and his or her ICT, as alternatives to or means to avoid high-cost traditional Medicare and Medicaid services. This flexibility will enable ICOs to better work with Enrollees to avoid or transition from acute and long-term care inpatient settings, if appropriate.

Additionally, Global Payments allow the following types of innovation not supported in the current Fee-for-Service (FFS) payment structure:

- The ICO Global Payment is not volume-based, but instead is expressly for developing integrated systems and Provider Networks to provide fully integrated care across medical and Behavioral Health services while ensuring access to appropriate independent living supports and LTSS.
- The ICO may make payments on a per-Member basis to Primary Care sites and Independent LTSS Coordinators to work with Enrollees, families and other key contacts to do initial and ongoing assessments, develop ICPs, assemble and convene ICTs, and provide coordination of services and connections to community resources. This approach over time will support the expansion of Primary Care sites that can function as Patient-Centered Medical Homes and Health Homes that meet the needs of people with disabilities.
- The ICO may pursue models that are more varied and collaborative, including mobile, home-based, or other non-office-based care, as well Primary Care provided in Behavioral Health settings.
- The ICO and ICT may employ or contract with a non-traditional, non-medical, health professional workforce (e.g., Community Health Workers) who are duly trained, certified and supervised.
- The ICO has the flexibility to direct resources to innovative approaches that meet the needs of specific high-need, high-cost populations (those affected by homelessness, chronic diseases, dual diagnoses, etc.).
- The ICO is strongly encouraged to utilize alternative payment methods to incentivize high-quality, integrated care throughout its Provider Network.

The proposed methodology for establishing the monthly Global Payment is summarized in **Figure 7-1** and further described in **Sections 7.2** through **7.6**. The final methodology is subject to CMS approval.

Figure 7-1: Summary of Payment Methodology under Massachusetts Demonstration to Integrate Care for Dual Eligible Beneficiaries

	Medicare A/B	Medicare D	Medicaid
Baseline costs	Composite of Medicare Advantage payments and Medicare standardized Fee-for-service payment rates, based on the expected costs for the proportion of the target population that will be transitioning from each program into the Demonstration.	National average monthly bid amount (NAMBA)	Historical State data. Trend rates developed by State actuaries, with oversight from CMS contractor and staff; projections completed by CMS actuary
Responsible for producing data	CMS	CMS	State Medicaid agency validated by CMS actuary
Risk adjustment	Medicare Advantage CMS-HCC Model	Part D RxHCC	State will use rating categories as described in **Section 7.2**, and High Cost Risk Pools (HCRP) described in **Section 7.5**.
Quality withhold	See **Section 7.6**	Not applied	See **Section 7.6**
Risk Mitigation	Combined (all eligible costs) ICO-level tiered Risk Corridors will be applied.	Existing Part D processes will apply	Combined (all eligible costs) ICO-level tiered Risk Corridors will be applied.

Section 7.2 Rating Categories (RCs)

The following rating categories are expected to be utilized in the Demonstration. Additional details on the definitions of the rating categories may be provided by MassHealth in supplemental instructions. The Rating Categories may be modified for Year 2 and/or Year 3 of the Demonstration.

- F1 – Facility-based Care. Includes individuals identified by MassHealth as having a long-term facility stay of more than 90 days.
- C3 – Community Tier 3 – High Community Needs. Includes individuals who do not meet F1 criteria, and have two or more Activities of Daily Living (ADL) limitations AND three days of skilled nursing need; and individuals with multiple ADL limitations; based on MDS-HC assessment.
- C2 – Community Tier 2 – Community High Behavioral Health. Includes individuals who do not meet F1 or C3 criteria, and who have one or more of the Behavioral Health diagnoses listed below, reflecting an ongoing condition such as schizophrenic or episodic mood disorders; psychosis; or alcohol or drug dependence not in remission.
    - 295.xx
    - 296.xx
    - 298.9x
    - 303.90, 303.91, 303.92
    - 304.xx excluding 304.x3
- C1 – Community Tier 1 – Community Other. Includes individuals in the community who do not meet F1, C2 or C3 criteria.

Section 7.3 Base Global Rates

ICO rates will be developed annually for each county by CMS in partnership with MassHealth based on baseline spending in both the Medicare and Medicaid programs and anticipated savings that will result from integration and improved care management. The Part D direct subsidy portion of the rate will be based on the standardized national average bid amount.

The Base Global Rates will be posted on Comm-PASS when they are available and will not be subject to negotiation.

Methodology for Setting Rates

A. Establish baseline and projected spending for target population in the Demonstration Service Area.

The baseline costs include three components: Medicaid, Medicare Parts A and B, and Medicare Part D.

Medicaid:

- MassHealth and its actuaries will be responsible for establishing the historic baseline spending for Medicaid services that will be included under the

Demonstration based on actual MassHealth FFS costs for the projected Dual Eligible target population.

- MassHealth and its actuaries will provide historical baseline data to the CMS-contracted actuary. CMS and its actuaries will develop projected Medicaid costs (absent the Demonstration)

Medicare Parts A/B:

- The Medicare baseline costs will be a composite of Medicare Advantage (MA) rates and Medicare standardized FFS county rates, depending on the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare baseline will also take into account other costs that would have occurred absent the Demonstration, including (but not limited to) administrative costs, quality bonus payments for existing contractors, and risk adjustment.
- For beneficiaries coming from Medicare FFS, CMS will develop baseline and projected costs for Medicare A and B services using the Medicare standardized FFS county rates. (Note: these rates are calculated by the CMS Office of the Actuary (OACT) as part of the annual Medicare Advantage Rate Announcement and released April 2, 2012, for CY 2013.)
- For beneficiaries coming from MA, the baseline will reflect the estimated amounts that would have been paid to MA plans in which the beneficiaries would have been enrolled in the absence of the demonstration

Medicare Part D:

- Medicare Part D direct subsidy projected baseline will be set at the Part D national average monthly bid amount (NAMBA) for the payment year. CMS will estimate an average monthly payment amount for the low-income cost sharing and Federal reinsurance subsidy amounts; these payments will be 100% cost reconciled after the payment year has ended..

  The CY 2013 Part D NAMBA will not be available until August 2012; for planning purposes, the CY 2012 Part D NAMBA is $84.50.

B. Aggregate savings targets under the Demonstration.

- EOHHS and CMS expect that this program can achieve savings while paying Participating Plans capitated rates that are adequate to support access and utilization of benefits according to beneficiary needs and preferences.
- An aggregate savings target will be determined based on modeling performed by the CMS-contracted actuary.

C. Apply aggregate savings target to each component of the integrated rate.

- The aggregate savings target will be applied to both the Medicare A/B and Medicaid baseline amounts established above. The Medicaid savings targets may vary by Rating Category but overall will equal the aggregate savings target

described above. Savings targets will not be applied to the Part D component of the rate.

D. Payments to ICOs for each component of the Global Payment rate.

- CMS will make separate payments to the participating health plans for the Medicare A/B and Part D components of the rate.
- The State will make a payment to the participating health plans for the Medicaid component of the rate.

Section 7.4 Risk-Adjustment

Apply risk adjustment methodology to each component of the integrated rate.

- The Medicare A/B component will be risk adjusted based on the risk profile of each Enrollee. The existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration.
- The Medicare Part D national average bid will be risk-adjusted in accordance with existing Part D RxHCC methodology.
- The Medicaid component will be based on rating categories and use a High-Cost Risk Pool (HCRP) for Rating Categories F1 and C3 to account for differences in risk among the eligible populations (see **Section 7.5** below). The state will be working on the development of an enhanced risk adjustment methodology during the course of the Demonstration.

Section 7.5 Risk Mitigation Strategies

A. Medicaid High-Cost Risk Pool

High-Cost Risk Pools (HCRP) will be established across ICOs for Rating Categories F1 and C3. Each pool will account for enrollment of high-cost Members within each Rating Category, based on spending on an defined set of services above a defined threshold. A portion of the base Medicaid capitation rate for each of Rating Categories F1 and C3 will be withheld from all ICOs into risk pools. The risk pools will be distributed annually across ICOs according to a methodology which is based on actual applicable expenses above the threshold amount for each of the Rating Categories. HCRP details including the applicable services, the thresholds and withhold amounts will be made available at the same time as the base capitation rates.

B. Risk Corridors

Subject to federal approval, Risk Corridors will be established to account for possible enrollment bias and to protect plans and payers until actual program experience is available. The Demonstration will utilize tiered ICO-level symmetrical risk corridors to include all Medicare A/B and Medicaid covered eligible costs. The risk corridors will be reconciled after application of any HCRP or risk adjustment methodologies (e.g., CMS-HCC), but prior to any performance incentive payments. The Contract

will include further details on how Risk Corridors will be used in this Demonstration, including the Risk Corridor tiers and the process for collecting cost information.

Section 7.6 Incentive Payments for Quality and Performance

EOHHS will provide Performance Incentives to ICOs that meet or exceed quality targets for care integration improvements. Each month EOHHS and CMS shall withhold a percentage of the ICO's approved capitation payment. The withhold percentage shall be equal to 1% in Year 1, 2% in Year 2 and 3% in Year 3. ICOs will be able to earn back the withhold percentage if they meet quality objectives.

The Year 1 measures are foundational measures that will be included in the Contract. In subsequent years there will be additive performance indicators that focus on use of non-traditional services and that address certain areas of focus, such as Behavioral Health, care integration and coordination, access, and LTSS.

A. In Year 1, encounter reporting and percent completion of the initial assessment within 90 days of enrollment will be utilized as the basis for the 1% quality withhold payment. Specific metrics will be included in the Contract.

B. The CMS national portion of the quality withhold measures (to be supplemented by State performance indicators) are expected to be finalized in the Contract:

(*Note*: Part D payments will not be subject to a quality withhold; however, ICOs will be required to adhere to quality reporting requirements that currently exist under Part D.)

Section 7.7 Non Payment and Reporting of Provider Preventable Conditions

Pursuant to 42 C.F.R. § 438.6(f)(2), all payments to the ICO are conditioned on the ICO's compliance with all provisions related to Provider Preventable Conditions

SECTION 8. RFR RESPONSE SUBMISSION INSTRUCTIONS

Section 8.1 General Response Submission Instructions

A. Responses to this RFR must consist of one original, five copies, and two CDs of each of the following two separate documents:

1. the Respondent's Business Response as described in **Section 9**, including any required attachments or certifications; and
2. the Respondent's Programmatic Response as described in **Section 10**, including any required attachments.

The Response documents on the CD must be formatted to be compatible with Word 2003 (i.e., not in .pdf format). Required forms and other attachments, such as financial documents, should be included on the CD when feasible.

B. Each document submitted shall include all information that is specific to the topic of the document as required by this RFR.

C. Each original and each copy must be clearly labeled and state:

1. the title of this RFR;
2. the bidding entity's legal name; and
3. the title of the response document contained in the binder.

D. Each original and copy must be double-sided, unbound, reproducible, and submitted in a three-ring loose-leaf binder. Each page should include the name of the Respondent organization for easy identification. Respondents should submit materials in a format that allows for easy removal and recycling of paper materials. Unless absolutely necessary, all responses and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves and GBC binding.

E. The narrative section of each document shall be formatted as follows:

1. Typed;
2. Single-spaced;
3. One-inch or greater margins;
4. The equivalent of 11-point font (or larger), except in tables and graphs, where 10-point font may be used.

F. Electronic media submissions such as videotapes, audiotapes, CDs or DVDs – other than the required electronic copy on CD – will not be accepted. Facsimile and e-mailed responses will not be accepted.

G. The page limit for the Respondent's Programmatic Response (**Section 10**) is 125 pages. Pages beyond this page limit may be disregarded by the Evaluation Committee. EOHHS has not applied individual page limits to the Respondent's Business Response.

H. Attachments, such as sample materials and charts and any other supporting documentation explicitly required by this RFR, are not counted in calculating the Respondent's page limits. However, except where attachments are specifically allowed, Respondents may not expand its responses to the programmatic questions with attachments. Do not submit unnecessary samples, attachments or documents not specifically requested.

Section 8.2 Organization of Response

A. Each document response shall contain a Table of Contents with page numbers for each primary, secondary, and tertiary section of the response (e.g., Section 8.2.A, 8.3.D, etc.).

B. Each section of the response shall be separated by a tabbed (or otherwise similarly indicated) page that references the RFR section number and heading.

C. The Respondent shall respond to each item in the order in which it appears in the RFR, and shall use headings and numbering to match the corresponding section from the RFR.

D. To maximize the clarity of the response and ease of evaluation, in the event that a question or item is not applicable to the Respondent, the Respondent shall reference such question or item number and state "Not Applicable." Failure to reference a question will be deemed to be an omission and will be given a score of "Non-Responsive."

E. EOHHS assumes no responsibility for knowledge of any material that is not presented in accordance with EOHHS's instructions.

Section 8.3 Cover Letter

The Respondent shall prepare a cover letter to accompany its response, which should be included in the Programmatic Response binder. The cover letter must be signed by an individual authorized to negotiate for and execute the Contract on behalf of the Respondent. It must state the following:

A. the name, e-mail address, and telephone number(s) of the individual who should be contacted for the purpose of discussing any aspect of the Respondent's response;

B. that the Respondent's response is effective through the date a Contract is executed;

C. the County or Counties for which the Respondent is submitting a proposal; and

D. that the Respondent meets all qualifications included in **Section 1.7**.

Section 8.4 Document Submission

The Respondent shall submit both of the response documents in separate packages/boxes to the following address no later than the date and time specified in **Section 12**. Each sealed envelope or package shall be labeled in the manner specified in **Section 8.1** and shall be addressed to:

Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108
Attention: Geraldine Sobkowicz, Procurement Coordinator

Any response received after the deadline will be rejected.

SECTION 9. BUSINESS RESPONSE REQUIREMENTS

Section 9.1 Required Forms

The Respondent must submit the following Commonwealth-required forms with its Business response. All of the referenced forms and certifications may be downloaded from the "Forms and Terms" tab for this solicitation on the Comm-PASS website (refer to **Section 13.3** for information about Comm-PASS).

- Commonwealth Terms and Conditions
- Standard Contract Form
- W-9 Request for Verification of Taxation Reporting Information
- ICO Authorization Signatory List
- Supplier Diversity Program (see **Section 13.17**)
- Prompt Payment Discount Form
- Consultant ICO Mandatory Submission Form
- Federally Required Disclosures Form (to be posted at a later date)

Section 9.2 Ownership and Control

Required documentation for this section of the RFR must be included in the Business Response.

A. If the Respondent is a not-for-profit corporation, the Respondent must provide the following documents:

1. A current original "Short Form Certificate of Legal Existence," which Massachusetts corporations may obtain for a nominal fee from:

   Secretary of State's Office
   Corporate Division
   One Ashburton Place – Room 1715
   Boston, MA 02108

   Note: Foreign (non-Massachusetts) not-for-profit corporations must submit equivalent documentation from the Secretary of State where incorporated and a copy of the corporation's Massachusetts Foreign Corporation Certificate; and

2. A current original Clerk's Certificate certifying that the individual executing the Contract on behalf of the Respondent has the authority to do so, and listing the names and titles of all current officers.

B. If the Respondent is a for-profit corporation, the Respondent must provide the following documents:

1. A current original "Short Form Certificate of Legal Existence with Officers," which Massachusetts corporations may obtain for a $12 fee from the Secretary of State's Office at the address listed above. Note: Foreign (non-Massachusetts) for profit corporations must submit equivalent documentation from the Secretary of State where incorporated and a copy of the corporation's Massachusetts Foreign Corporation Certificate; and
2. A current original Clerk's Certificate certifying that the individual executing the Contract on behalf of the Respondent has the authority to do so.

C. If the Respondent is not a corporation (for example, a limited partnership or a trust), the Respondent must provide appropriate evidence of legal existence and status.

D. If the Respondent does business under any different name or names, the Respondent must provide a listing of any such names, including a copy of the d.b.a. certificate(s) or other filing(s) in the locality in which the Respondent does business under such different name or names.

E. If the Respondent must disclose information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, subpart B, and with the applicable requirements of 42 U.S.C. § 1396b(m)(4)(A). Such disclosure must include the identity, address, and financial statements of any person or corporation that has five percent or more ownership or controlling interest in the Respondent.

Section 9.3 Location

The Respondent must specify the following:

A. the business address, telephone number, and business hours of the Respondent's principal place of business; and

B. the business address, telephone number, and business hours of any site(s) other than the Respondent's principal place of business that will be used for directing or administering the Covered Services to be provided under the Contract.

Section 9.4 Legal Actions

A. Compliance with Laws

1. As part of its Business Response, the Respondent must state whether the Respondent, its parent, subsidiary, affiliate or Material Subcontractor:
    a. Is the subject of any current litigation or findings of non-compliance under state or federal law;
    b. In the past three years, has had any claims, judgments, injunctions, liens, fines or penalties secured by any governmental agency;

c. Has any outstanding liabilities to the Internal Revenue Service or any other government agency (state or federal); or

d. In the past three years, had any governmental audits that revealed material weaknesses in its system of internal controls, compliance with contractual agreements, and/or laws and regulations or any material disallowances.

2. If the Respondent responds affirmatively to any item above, the Respondent shall briefly describe the circumstances including, but not limited to, the regulatory agency or authority, a description of the deficiency, corrective actions, findings of non-compliance, and/or sanctions. The Respondent shall also indicate which of these actions or fines, if any, were related to Medicaid, Medicare or SCHIP programs.

B. Compliance with Contracts

1. As part of its Business Response, the Respondent must state whether the Respondent, parent, subsidiary, affiliate or Material Subcontractor:

   a. Has ever had a contract terminated or not renewed for poor performance or non-performance; or

   b. Has had any warnings, sanctions or corrective action requirements imposed for non-compliance with Contract terms.

2. If the Respondent responds affirmatively to any item above, the Respondent shall briefly describe the circumstances, including but not limited to, the name of the state and contracting entity, the product line (Medicaid, Medicare or commercial), the date and description of the violation or findings of non-compliance, and a description of the action taken (e.g., warning, fine, contract termination).

Section 9.5 Conflict of Interest

As part of its Business Response, the Respondent (on its own behalf and for any parent, subsidiary, affiliate or Material Subcontractor) must:

A. Acknowledge that, in governmental contracting, even the appearance of a conflict of interest is harmful to the interests of the State; and therefore, the Respondent agrees to take measures to ensure that its officers, employees, agents, consultants and/or sub-ICOs comply with applicable ethical standards and requirements of the Massachusetts Conflict of Interest law, M.G.L. c. 268 A;

B. Acknowledge that no officer, employee, agent, consultant and/or sub-ICO of the Respondent participated in developing or drafting any grant or funding applications, contract or other specifications, requirements, scope of work, related to or in connection with this RFR; and

C. Disclose any potential or actual conflict of interest, including but not limited to, any relationship or interest, financial, business, beneficial or otherwise, which is in conflict with the proper discharge of their responsibilities described under the RFR

and Contract. If there is no conflict(s) of interest, so indicate. In cases where such relationship (s) and/or interests exist or appear to exist, the Respondent shall describe how a potential or actual conflict of interest will be avoided.

Section 9.6 Organizational Overview of Management and Policymaking Bodies

The Respondent's response to **Sections 9.6.A, B** and **C** shall not exceed 15 pages, excluding the résumés, job descriptions, organizational charts, and references required below.

A. Organizational History, Ownership, and Governance

The Respondent shall:

1. Provide the following information:
    a. The Respondent's legal name, trade name(s), and any other name(s) under which the respondent does, or has done, business; and
    b. The Respondent's Federal Employer Identification number (FEIN).
2. State whether it is a Minority Business Enterprise as defined in **Section 13.17**.
3. Provide a brief summary of the organizational history, including date of first incorporation, organizational goals, and the relevance of Medicaid and Medicare managed care to the mission of the organization.
4. State the reasons the Respondent is interested in bidding on the Contract, and in serving Medicare and MassHealth Members under the Contract.
5. Briefly summarize its experience and qualifications relevant to the Contract including, but not limited to: experience it has serving comparable populations under Medicaid/SCHIP, commercial or Medicare populations; experience providing comparable services on a capitated basis; innovations in care or disease management; and financial performance.
6. Submit an organizational statement (mission, organizational structure, philosophy, and plans for future growth and development).
7. Submit an organizational chart of the Executive Management Staff of the Respondent organization and an organizational chart of the Contract, including functional titles and names of incumbent individuals; and
8. Résumés. Submit the résumés of the individuals in the Respondent's organization holding the following (or similarly titled) positions:
    a. Chief Executive Officer;
    b. Chief Financial Officer;
    c. Chief Operating Officer;
    d. Chief Medical Officer;
    e. Director of Quality Management;

f. Behavioral Health Clinical Director or equivalent;

g. Director of Long-Term Services and Supports or equivalent; and

h. ADA Compliance Officer, or equivalent.

B. Key Personnel and Staffing

In this subsection, the Respondent shall provide its proposed staffing plan to fully implement the required scope of services. The Respondent shall provide the following information:

1. a summary of the qualifications of the Respondent's proposed key personnel;
2. the total number of full-time equivalent (FTE) for each of the Respondent's proposed key personnel assigned to this project;
3. detailed résumés, which include qualifications, credentials and experience, of the individuals proposed to hold each key personnel position. The résumés shall contain information regarding education, background, and relevant recent work experience. The Respondent should highlight experience with specific related projects;
4. a description of the Respondent's plans, including timelines, to recruit staff for any key personnel positions not currently filled and what experience and skills the Respondent would be looking for in the staff it would recruit;
5. an organizational chart that identifies key personnel for the project, senior managers, and other staff by title to be assigned to accomplish the work described in this RFR; and
6. the name, title, and qualifications of the person within the Respondent's organization who will be designated as the Contract manager and be responsible for the ongoing day-to-day management of the activities described in this RFR.

C. Material Subcontractors

If the Respondent proposes to subcontract with a Material Subcontractor for any services (either exclusively, or in combination with any other services under the Contract), the Respondent shall, for each proposed Material Subcontractor identify the services to be performed by the Material Subcontractor and:

1. Provide all of the information in **Section 9.6.A**, below, for each Material Subcontractor; and
2. Submit the résumé of the individual in each Material Subcontractor organization responsible for overseeing such Material Subcontract.

Section 9.7 Financial Ability

The Respondent must demonstrate its ability to meet the requirements of the Contract by submitting the following (which must relate to the specific legal entity that will execute

the Contract and which will be directly responsible for the Contract – i.e., not the parent organization):

A. Independently certified audited financial statements for the three most recent fiscal-year periods including all Medicaid and Medicare components. Clearly indicate the fiscal-year period (for example, July through June or January through December). Audits must include:

1. Opinion of a certified public accountant;
2. Statement of revenues and expenses;
3. Balance sheet;
4. Statement of cash flows;
5. Explanatory notes;
6. Management letters;
7. Statements of changes in net worth; and
8. IBNR (incurred but not reported) actuarial statement for the most recent fiscal year period;

B. A copy of the most recent unaudited financial statement of the Respondent;

C. If the entity is a public corporation or subsidiary of a public corporation, the most recent annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934, Form 10-K;

D. If the entity has raised capital through public offerings within the last three years or anticipates a public offering, a copy of the prospectus; and

E. Enrollment and financial projections, including:

1. Enrollment projections for each Contract Year by Rating Category, and the methodology for these projections;
2. Financial projections for a minimum of three years from the date of the latest submitted financial statement. Describe financing arrangements and include all documents supporting these arrangements for any projected deficits. Provide evidence of financing arrangements for any projected deficit;
3. Financial projections using the accrual method of accounting in conformity with generally accepted accounting principles. Medicare and Medicaid revenues must be included. Prepare projections using the pro-forma financial statement methodology. Projections must include the following:
    a. Quarterly balance sheets for the Respondent, using the General Accepted Accounting Principles (GAAP) Financial Report #1 format;
    b. Quarterly projections of revenues and expenses for the legal entity, using GAAP Financial Report #2 format, including:

1) Projections in gross dollars as well as on a per-Member per-month basis;
2) Quarters consistent with standard Contract Year quarters;
3) Year-end totals; and
4) An explanation if an organization has a category of revenue or expense that is not included in the present definitions;

c. Quarterly cash flows, using the GAAP Financial Report #3 format;

d. Justification of assumptions. State major assumptions in sufficient detail to allow an independent financial analyst to reconstruct projected figures using only the stated assumptions. Include operating and capital budget breakdowns; and

e. In stated assumptions, address all periods for which projections are made and include inflation assumptions. Justify assumptions to the extent that a knowledgeable reviewer would be convinced that they are reasonable. Base justification on such factors as the Respondent's experience and the experience of other health plans. Describe hospital and health professional costs and utilization in detail.

Section 9.8 Financial Solvency Standards

A. Respondents must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the entity's debts if the entity becomes insolvent. CMS and the State shall establish a standard for all ICOs to demonstrate financial solvency that could include one of the following: 1) the solvency requirements for Medicare Advantage organizations at 42 C.F.R. § 422.402 et seq.; 2) the solvency requirements for Medicaid managed care organizations at 42 U.S.C. § 1396b(m)(1); 3) the solvency requirements for PACE providers at 42 C.F.R. § 460.80; or 4) other solvency standard as agreed upon in writing by CMS and the State.

B. State whether the Respondent, parent, subsidiary or any affiliate:

1. In the past seven years, has had any bankruptcy proceeding initiated against it (whether or not such proceedings are closed);
2. Has any bankruptcy proceedings currently pending against it, regardless of date of filing;
3. Is currently insolvent, or has reason to believe that an involuntary bankruptcy proceeding may be brought against it; or
4. Has ever been in receivership.

If the Respondent answers affirmatively to any of the items above, the Respondent shall provide a detailed explanation and attach any relevant supporting documentation, including documentation on how the preceding will be addressed without an adverse impact on the Respondent's ability to meet all Contract requirements.

C. Submit the following financial documentation:

1. Letters of financial support, credit, bond, loan guarantee, letter of parental guarantee, reserve guarantee, or other financial guarantees, if any, in at least the same amount that guarantees that the obligations under the Contract will be performed, or the Respondent's plan to acquire such guarantees;
2. A detailed statement of the Respondent's plan to establish and maintain reserves or other funds as determined necessary to cover any risks projected and not otherwise assumed by another entity, carrier or reinsurer; a detailed statement of current and projected reserve establishment calculations, amounts, purpose and use of reserve, and assumptions and bases thereof, including, but not limited to, identification of reserves set aside to meet uncovered reinsurance items;
3. Copies of all reinsurance, conversion or other agreements with other insurers, health providers, medical service corporations, hospital service corporations, governmental agencies or organizations or other MCOs to provide payment for the cost of, or to provide the contracted health care services in the event the Respondent is unable or ceases to provide contracted health services for any reason;
4. The Respondent shall maintain, at its own expense, and shall ensure that any of its subsidiaries, affiliates or Material Subcontractors maintain at their own expense, insurance in standard amounts to cover workers' compensation, public liability and property damage insurance, medical malpractice and professional liability insurance and any other insurance that may be necessary for the performance of the work under the Contract. As part of its Business Response, the Respondent must provide EOHHS and CMS with certificates of the above insurance coverage.
5. A statement of the Respondent's accounting system and organization, management and internal controls, method of estimating and handling incurred but not reported (IBNR) liabilities;
6. A detailed description of mechanisms to monitor the financial solvency of any independent practice association, group practice, or other organization contracting with the respondent that assumes substantial financial risk through capitation or other prepaid risk-sharing or risk-transferring arrangements, where substantial financial risk shall mean prepayments totaling more than 5% of the Respondent's annual health care expense; and
7. A certificate from the taxing authority of the state in which the Respondent has its principal office, attesting that the Respondent is not in default of any obligation under its tax laws. To illustrate this requirement, corporations with principal offices in Massachusetts would satisfy this requirement by submitting a "Certificate of Good Standing" issued by the Massachusetts Department of Revenue (DOR). Instructions for obtaining the DOR certificate may be found on the Commonwealth of Massachusetts DOR website at http://www.massdor.com/help/goodstanding.htm.

D. To demonstrate its ability to meet the solvency requirements that will be required of all ICOs under the Contract, the Respondent must:

1. Describe the Respondent's provisions for the event of insolvency, including:
    a. The continuation of benefits for the duration of the period for which capitation payment has been made;
    b. Continued provision of Covered Services to Enrollees for a period of at least 45 calendar days from the date of the Applicant's insolvency, and until coverage for all Enrollees (for example, enrollment with another managed care organization, or Medicare Fee-For-Service and Medicaid Fee-For-Service) has been re-established, including referrals to Primary Care and other providers; and
    c. Continued provision of Covered Services to Enrollees through discharge for Enrollees who are in inpatient facilities on the date the Respondent's Contracts with CMS and EOHHS terminate or in the event of the Respondent's insolvency;
2. Describe how the Respondent will protect Enrollees and EOHHS from liability for expenses that are the legal obligation of the Respondent;
3. Describe the Respondent's arrangements to pay for services furnished by providers that do not contract or otherwise have not entered into an agreement with the Respondent; and

Submit documents that demonstrate that the Respondent's arrangements, in the event the Respondent becomes insolvent, to cover expenses and ensure continued provision of Covered Services to Enrollees for at least 45 calendar days following the date of the Respondent's insolvency. Arrangements to cover expenses may include insolvency insurance or reinsurance, performance bonds, irrevocable letters of credit, parental guarantees, or restricted reserves.

Section 9.9 Reporting/Computer Capacity

The Respondent shall:

A. Describe its:

1. Capacity and process for sending and receiving HIPAA-compliant data
2. The proposed resources dedicated to such exchanges; and
3. The processes and controls the Respondent has in place to maintain data integrity.

B. Submit its internal standard for completeness and accuracy of encounter data.

C. Describe the process the Respondent uses to validate the completeness and accuracy of its data, including but not limited to encounter data; and

D. Describe the process the Respondent uses to capture encounters with Providers who are paid on a capitated basis.

Section 9.10 Management Information Systems (MIS)

A. The Respondent shall describe in detail the Management Information System (MIS) Respondent proposes to use in performance of Contract obligations, including how the MIS will comply with all of the requirements of the RFR.

1. General Requirements

   The ICO shall:

   a. Maintain an MIS that will enable the ICO to meet all of EOHHS and CMS' requirements as outlined in this RFR or the Contract. The ICO's MIS shall be able to support current EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following EOHHS standards:

      1) The EOHHS Unified Process Methodology User Guide;

      2) The User Experience and Style Guide Version 2.0;

      3) Information Technology Architecture Version 2.0; and

      4) Enterprise Web Accessibility Standards 2.0.

   b. Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor, EOHHS, CMS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS;

   c. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information. If directed by EOHHS or CMS, establish appropriate links on the ICO's website that direct users back to the EOHHS website portal;

   d. The Contractor shall cooperate with EOHHS or CMS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS or CMS; and

   e. Actively participate in any EOHHS MIS Workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS.

2. Design Requirements

   a. The ICO shall comply with EOHHS requirements, policies, and standards in the design and maintenance of its MIS in order to successfully meet the requirements of the Contract.

   b. The ICO's MIS shall interface with, EOHHS's MIS system, the EOHHS Virtual Gateway, and other EOHHS IT architecture that may be specified in the Contract.

c. The ICO shall have adequate resources to support the MIS interfaces. The ICO shall demonstrate the capability to successfully send and receive interface files. Interface files, include, but are not limited to:

1) Inbound Interfaces

a) Daily Inbound Demographic Change File;

b) HIPAA 834 History Request File;

c) Inbound Co-pay Data File (daily); and

d) Monthly ICO Provider Directory.

2) Outbound Interfaces

e) HIPAA 834 Outbound Daily File;

f) HIPAA 834 Outbound Full File;

g) HIPAA 834 History Response;

h) Fee-For-Service Wrap Services;

i) HIPAA 820; and

j) TPL Carrier Codes File.

d. The ICO shall conform to HIPAA-compliant standards for data management and information exchange.

e. The ICO shall demonstrate controls to maintain information integrity.

f. The ICO shall maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS.

3. System Exchange of Encounter Data

a. The ICO's MIS shall generate and transmit encounter data files according to the specifications outlined in **Appendix H**, as may be updated by EOHHS for this Demonstration;

b. The ICO shall maintain processes to ensure the validity, accuracy and completeness of the encounter data; and

c. The Contractor shall participate in any workgroup activities as specified above.

4. System Access Management and Information Accessibility Requirements

a. The ICO shall make all MIS and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and MIS.

b. The ICO is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

5. System Availability and Performance Requirements

a. The ICO shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers 24 hours a day, seven days a week.

b. The ICO shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the ICO's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to EOHHS upon request. In the event of system failure or unavailability, the ICO shall notify EOHHS upon discovery and implement the COOP immediately.

c. The ICO shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

B. At a minimum, the Respondent shall:

1. Identify the length of time the Respondent has been utilizing the MIS proposed for the Contract;
2. Identify hardware and system architecture specifications;
3. Identify all proposed functions and data interfaces;
4. Describe data and process flows for all key business processes identified in above;
5. Attest to the availability of the data elements required to produce required management reports;
6. State whether the Respondent has used the proposed MIS for fewer than two years and, if so, state how the Respondent will assure system stability; and
7. Describe in detail any system changes or enhancements, including subcontracting all or part of the system to a Material Subcontractor or to a different Material Subcontractor, that the Respondent is contemplating making during the term of the Contract. Such description shall include a description of how the Respondent will ensure the continuity of all operations. For the purpose of this question, "system" shall refer at a minimum to any of the following systems or subsystems:
   a. Enrollment;
   b. Claims processing;
   c. Utilization Management/Service Authorization; or
   d. Care Management/Disease Management.

C. System Architecture

The Respondent shall:

1. Describe in detail the capacity of the Respondent's IT system to support all statutory and regulatory requirements applicable to Enrollee medical records, including, but not limited to those contained in 130 CMR 433.409 and 450.205,

and any amendments thereto and 42 C.F.R. § 456.211. Specifically, the Respondent shall:

a. Describe its ability to interface with EOHHS's systems. This shall include a description of the Respondent's experience establishing and maintaining electronic interfaces with other entities (purchasers or other program contractors); and

b. Submit diagrams that illustrate (i) point-to-point interfaces; (ii) information flows; and (iii) the networking arrangement (a/k/a "network diagram") associated with the MIS described in above.

2. Describe in detail the Respondent's proposed Web Portal functions for Enrollees and Providers, including but not limited to:

   a. Proposed content;

   b. Self-service functionality, including description of proposed functions and related training, on-line or telephonic support for such functionality;

   c. A site map and description of how the proposed website for the Contract relates to the Respondent's organization site and sites for other lines of business;

   d. The Respondent's ability to track Enrollee and Provider utilization of Web-based information and tools;

   e. Any proposed links, for example, to the website of a Material Subcontractor; and

   f. System availability, and any built-in downtime.

3. The Respondent shall submit screen shots for the proposed website for the Contract, and screen shots for any existing websites for other Medicaid or Medicare contracts.

Section 9.11 Claims Processing

The Respondent shall:

A. Describe its proposed claims processing and claims payment processes and systems, including how the Respondent proposes to comply with payment requirements.

1. The Contractor shall make payment on a timely basis to Providers for Covered Services furnished to Enrollees, in accordance with 42 U.S.C. § 1396u-2(f) and 42 C.F.R. § 447.46. Unless otherwise provided for and mutually agreed to in a contract between the Contractor and a Provider that has been reviewed and approved by EOHHS, the Contractor shall:

   a. Pay 90% of all claims that can be processed without obtaining additional information from the provider of the service or from a third party for Covered Services from Providers within 30 days from the date the Contractor receives the claim. It may not include a claim from a Provider who is under

investigation for fraud or abuse, or a claim under review for Medical Necessity;

b. Pay 99% of all claims from Providers within 90 days from the date the Contractor receives the claims that can be processed without obtaining additional information from the provider of the service or from a third party for Covered Services from Providers. It may not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity; and

c. Submit a claims processing annual report.

B. Describe its ability and experience in allowing providers to submit claims electronically and its ability and experience in processing electronic claims payments to providers:

1. If currently accessing claims electronically, generally describe the type and volume of provider claims received electronically in the previous year versus paper claims for each claim type; and
2. If currently making claims payments to providers electronically, generally describe the type and volume of provider claims processed electronically.

Section 9.12 Onsite Readiness Review

CMS and EOHHS will conduct an onsite readiness review of each selected Respondent. Selected Respondents must meet all criteria prior to the signing of a Contract. As part of this review, Respondents should be prepared to submit the following Commonwealth-required forms and RFR required certifications: All of the referenced forms and certifications will be made available under the "Forms and Terms" tab for this solicitation on the Comm-PASS website (refer to **Section 13.3** for information about Comm-PASS).

- Certification of Non-Collusion
- Certification Regarding Debarment and Suspension
- Certificate of Good Standing
- EOHHS-Required Respondent Certifications

Additional Information about this Certificate may be found at:
https://wfb.dor.state.ma.us/webfile/Certificate/Public/WebForms/Help/LearnMore.aspx

SECTION 10. PROGRAMMATIC RESPONSE REQUIREMENTS

Section 10.1 Service Area

The Respondent must demonstrate its ability to meet the requirements of this RFR by submitting a detailed map (with a scale) of the complete list of counties or partial counties that will comprise the ICO Service Area, clearly showing the boundaries, main traffic arteries, and any geographic features such as mountains and rivers. The map must include the locations of hospital providers, home and community-based Long-Term

Services and Supports providers, nursing facilities and primary care practices within the Service Area.

The Respondent must note any differences in the Service Area proposed in this response versus the Service Area described in the Respondent's CMS CFA Demonstration Plan Application submitted to CMS. If there are any differences, the Respondent must update its Application via email to CMS no later than June 22, 2012. Those updates may only constitute a drop of one or more full or partial counties; a Respondent may not add to their Service Area at any point after the initial Application has been submitted to CMS.

Section 10.2 Experience Serving the Population and Providing the Services

A. The Respondent shall summarize its understanding of the social model of disability[*], the independent living philosophy and the recovery model, and how it intends to translate these principles into the delivery of integrated, disability-competent care for Dual Eligibles.

B. Respondent shall summarize its understanding of disability as a culture, and describe how it will develop Cultural Competencies including but not limited to: communicating effectively with patients who are Deaf, understanding the values and needs of persons with disabilities; respecting the knowledge a person with a disability has about their disability and its impact on his or her life, encouraging self-advocacy skills of patients and families; understanding accessibility and the need for accessible medical and diagnostic equipment; and acknowledging the core values of Disability Culture including the emphasis on independence. This response must include information on the training the Respondent will require for ICO staff and contracted providers on these competencies.

C. The Respondent shall describe its experience and that of any Material Subcontractor in serving adults with disabilities, including those who are eligible for Medicaid or Medicare or dually eligible. Please answer separately as the Respondent and for each Material Subcontractor. Summarize experience for each of the following populations:

- Adults with physical disabilities;
- Adults with Developmental Disabilities;
- Adults with Serious Mental Illness;
- Adults with substance use disorders;
- Adults with disabilities with multiple chronic illnesses or functional or cognitive limitations; and
- Adults with disabilities who are homeless.

Such summary shall include, for each population:

[*]The social model of disability has been developed by people with disabilities in response to the medical model and the impact it has had on their lives.

- The number of individuals served (a point-in-time estimate of the number of Enrollees, provide the date of the point in time) and in which state(s);
- Financing arrangements (e.g., risk-based, Fee-For-Service, cost-based contract);
- Payer (Medicaid, Medicare and commercial);
- Scope of services with which Respondent and Material Subcontractor(s) have experience;
- LTSS needs and service use of the population, as relevant;
- Strategies for managing and coordinating care, including LTSS as relevant;
- Experience managing Behavioral Health services for the population, including experience engaging individuals in Behavioral Health services and care management;
- Any noteworthy clinical or financial findings; and
- Any noteworthy quality improvement initiatives and quality measures, including client satisfaction surveys and results that resulted in improved Member outcomes, improved quality of care in service delivered by providers, and describe program modifications that were made as a result.

Section 10.3 References

A. The Respondent shall provide written references from organizations with whom the Respondent has, or has had, business experience, preferably involving the provision of all or most of the Covered Services to be provided under the Contract. The Respondent shall provide a written reference from each entity described below, which the entity shall mail directly to EOHHS at the address listed in **Section 8.4**. If the Respondent cannot provide the number of references of the type described in this section, the Respondent shall state why not.

1. Provide three references from consumer organizations, advocacy organizations, or provider associations for LTSS with whom the Respondent has worked in the past. If no prior experience, provide three references from consumer organizations, advocacy organizations, or provider associations for LTSS with whom the Respondent intends to work to fulfill its responsibilities under the Contract.
2. Provide three references from consumer organizations, advocacy organizations, provider associations or clinical professional organizations for Behavioral Health with whom the Respondent has worked in the past. If no prior experience, provide three references from consumer organizations, advocacy organizations, or provider associations for Behavioral Health with whom the Respondent intends to work to fulfill its responsibilities under the Contract.

B. In addition, the Respondent shall submit references from the following entities, provided that such entities shall not be affiliated with the Respondent:

1. One reference shall be from an acute hospital;
2. One reference shall be from a long-term care facility;

3. One reference shall be from a provider of home or community-based LTSS to individuals with chronic disabilities; and
4. One shall be from a physician group or primary care group practice.

C. All references provided shall include, at a minimum, the following information about the Respondent's contract with the organization providing the reference:

1. The name, address, and telephone number of the organization; and name, telephone number, and email address of the person EOHHS should contact as a reference;
2. A summary of the scope of the contract;
3. The duration and effective period of the contract;
4. The Respondent's experience providing any of the Covered Services to be provided under the ICO Contract;
5. An assessment of the Respondent's performance, including any corrective actions or quality improvement projects undertaken and the results of such actions and projects;
6. Whether payments under the contract were capitated or non-capitated; and
7. The number of covered lives served by the contract.

D. By submitting these references, the Respondent agrees that EOHHS may, at its option, contact these references.

Section 10.4 Covered Services and Provider Network

A. The Respondent shall describe its plan to provide the Covered Services described in **Section 4.2** (and **Appendix C**). The Respondent shall:

1. Describe any Material Subcontractors that will be used to provide any Covered Services, including dental, vision, pharmacy and any other benefits.
2. Describe its plan to ensure that services, including any provided through Material Subcontractors, are coordinated, integrated and delivered in a person-centered manner to maximize independent living, community-based care, and the health and well-being of Enrollees.
3. Describe the pharmacy formulary, including what level of co-payments will be required for pharmacy.
4. Describe if/how its formulary is broader than the minimum required by CMS as for Medicare Part D Plans.

B. The Respondent shall describe its approach to and plan for contracting with a Provider Network to ensure access and quality of Covered Services. The Respondent shall:

1. Describe how it will ensure that the number and types of providers are sufficient to meet the needs of the projected enrollment in each Service Area and provide for all Covered Services. Include evidence of network provider contracts already in place, and the plan (including timeline) for contracting with additional providers to deliver the covered services.
2. Describe how it will ensure that Enrollees will have a choice of providers for each of the Covered Services.
3. Describe what it has done to conduct outreach to and contract with providers (including Primary Care, specialists, Behavioral Health, and LTSS providers) and Community-Based Organizations that have existing relationships with each of the following populations in each proposed Service Area:
    - Adults with physical disabilities;
    - Adults with Developmental Disabilities;
    - Adults with Serious Mental Illness;
    - Adults with substance use disorders;
    - Adults with disabilities with multiple chronic illnesses or functional or cognitive limitations; and
    - Adults with disabilities who are homeless.
4. Describe what it has done to identify, outreach to and contract with providers who can effectively communicate with Enrollees who are Deaf or hard of hearing.
5. Describe a work plan, to be implemented and overseen by the ADA compliance officer, for ensuring adequate access to Covered Services for all Enrollees in accordance with state and federal laws for persons with disabilities by ensuring that Network Providers are aware of and comply with such laws so that physical and communication barriers do not inhibit Enrollees from obtaining services. Reasonable accommodations to ensure effective communications include auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:
    a. Providing large-print versions (at least 16-point font) of all written materials to individuals with visual impairments;
    b. Ensuring that all written materials are available in formats compatible with optical recognition software;
    c. Reading notices and other written materials to individuals upon request;
    d. Assisting individuals in filling out forms over the telephone;
    e. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;
    f. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf and hard of hearing;
    g. Accessible equipment such as exam tables, weight scales and diagnostic equipment; and

h. Individualized assistance.

6. Describe its plan for training members of the Provider Network in the service delivery model and disability competency.
7. Describe what it has done to identify, conduct outreach to and contract with providers to ensure effective access to medical care and LTSS for clients with diverse ethnic and cultural backgrounds.
8. State how it will identify and correct for any provider shortages

C. Primary and Acute Medical Care Services and Network

The Respondent shall:

1. Describe its primary and acute medical care network of medical providers, including names of providers and the number and geographic distribution of each type of provider. Include information about areas of specialty and specialist providers available or planned for within the network. Describe how this network ensures geographic access as required in **Section 4.5**.
2. Describe a work plan, to be implemented and overseen by the ADA compliance officer, for evaluating and ensuring the full accessibility of its primary and acute medical care network for Enrollees with disabilities and diverse ethnic and cultural backgrounds. Accessibility includes physical access, accessible medical equipment (e.g., scales, examining tables, mammography equipment), communication access (e.g., on-site ASL interpreter services or video access to off-site interpreters, access to telephone devices that are hearing aid compatible, internet-based video relay service, and real-time text support), and programmatic access (e.g., flexible hours, same-day appointments for Urgent Care).
3. Describe how it will ensure that PCPs offer care that is responsive to the needs of Enrollees 24 hours a day, seven days a week.
4. Describe how the Respondent will promote and support the evolution of Patient-Centered Medical Homes (PCMHs) and/or Health Homes among its Primary Care network. Include specific plans and timelines for engaging with the Primary Care Providers and ensuring that providers move toward and become PCMHs that are financed when possible through Alternative Payment Methodologies.

D. Behavioral Health Services and Network

The Respondent shall:

1. Describe its Behavioral Health provider network, including names of providers and the number and geographic distribution of providers. Describe how this network ensures geographic access as required in **Section 4.5** and how the adequacy of the network will be monitored.
2. Describe what contracts it will have to ensure adequate capacity for Enrollees requiring acute psychiatric hospitalization.

3. Describe the process by which it plans to recruit interested and knowledgeable providers, including those who may have existing relationships with Enrollees.
4. Describe its plan to provide Behavioral Health Diversionary Services and recovery-focused community-based mental health and substance use services, as listed in **Appendix A**.
5. Describe a work plan, to be implemented and overseen by the ADA compliance officer, for evaluating and ensuring the full accessibility of its Behavioral Health network for Enrollees with disabilities and diverse ethnic and cultural backgrounds. Accessibility includes physical access, accessible medical equipment, communication access (e.g., on-site ASL interpreter services or video access to off-site interpreters, access to telephone devices that are hearing aid compatible, internet-based video relay service, and real-time text support), and programmatic access (e.g., flexible hours, same-day appointments for Urgent Care).
6. Describe what it has done to conduct outreach to and contract with Behavioral Health care providers and organizations that are knowledgeable about the recovery orientation, diversionary services and Behavioral Health integration in each proposed Service Area.
7. Describe its plan for ensuring that all Behavioral Health providers have had training in person-centered planning, Cultural Competence, Trauma-Informed Care, accessibility and accommodations, independent living, and recovery orientation and wellness principles.

E. Long-Term Services and Supports and Network

The Respondent shall:

1. Describe its LTSS provider network, including names of providers and the number and geographic distribution of providers. Describe how this network ensures geographic access as required in **Section 4.5**.
2. Describe its plan to provide Adult Day Health, Adult Foster Care, Day Habilitation, and Group Adult Foster Care services, including plans to utilize the expertise of existing LTSS providers to enhance its capacity to provide these services. Include evidence of any existing subcontracts or plans for subcontracts prior to the readiness review.
3. Describe its plan to provide Personal Care Attendant (PCA) Services that include cueing and monitoring as well as hands-on care, and the opportunity for Self-direction. Include evidence of any existing subcontracts or planned subcontracts with existing PCM Agencies and the functions such providers will perform, FIs, or other providers of PCA Services to enhance its capacity to provide these services.
4. Describe its plan to offer durable medical equipment services that include training in equipment usage, equipment repairs, modifications, seating clinics,

environmental aids and assistive/adaptive technology. Include a description of the expertise of staff or contract provider(s) who will deliver the service.

5. Describe its plan for ensuring an adequate network for all LTSS services in all proposed Service Areas.
6. Describe its plan for training members of the Provider Network in the service delivery model and disability competency. Provide a description of the proposed provider education program.
7. Describe its plan for providing care, monitoring and health status improvements for Enrollees residing in nursing facilities.
8. Describe its approach to providing services to Enrollees in psychiatric hospitals, chronic disease hospitals and rehabilitation facilities, providing specific information about how it will provide services to support these Enrollees to resume community living and how it will work with state agency-provided LTSS that Enrollees may also be receiving.
9. For ICOs that do not use PCM Agencies for evaluation, provide specific information about how the ICO will evaluate the need for PCA Services, including:
    - Who will perform PCA evaluations for the ICO?
    - What are the qualifications of the entities or individuals performing the evaluations?
    - What is the capacity to perform PCA evaluations in a timely manner?
    - What process the ICO will use to assign or refer enrollees for evaluations?

Section 10.5 Assessment and Care Planning

A. Initial Enrollee Contacts

The Respondent shall:

1. Describe how and within what time frame it will contact all new Enrollees to:
    - Welcome the Enrollee to the ICO;
    - Identify if the Enrollee has a guardian;
    - Make certain that any services needed to assure the Enrollee's health, safety and well-being are authorized and delivered;
    - Provide the Enrollee with immediate information about how to contact the ICO for needed services;
    - Schedule a face-to-face contact with the Enrollee for the purposes of conducting a comprehensive assessment and determining whether the Enrollee would like someone to accompany him/her during the assessment and whom and how meetings will be set to accommodate the participation of the others whom Enrollees identify that they would like to include;

- Identify Enrollee's current providers and others who may be providing services to the Enrollee currently, and obtain the Enrollees' consent to contact them;
- Identify the Enrollee's housing situation; and
- Assist the Enrollee in selecting a PCP, including the information and guidance that will be provided to Enrollees to facilitate their choice of PCP.

2. Describe its strategy and process for establishing initial contact with and engaging new Enrollees who may have Serious Mental Illness, be hospitalized, have no telephone, or be homeless. Include any outreach strategies and collaborations with Community-Based Organizations that may be helpful in locating hard-to-reach individuals. Describe how the Respondent will contact and how many attempts will be made to contact individuals and engage them in assessment and care planning.
3. Describe its process for contacting and assessing new Enrollees who have disabilities, including those who are Deaf or hard of hearing.

B. Continuity of Care

The Respondent shall:

1. Describe the process it will use to provide Enrollees with Covered Services beginning on the first date of enrollment, including identifying all services and/or supports the Enrollee is receiving at the time of enrollment that are necessary to ensure health and safety and continuity of care until such time as an ICP is completed and signed by the Enrollee.
2. Describe its continuity of care process that allows qualified and willing providers already serving eligible Enrollees wishing to maintain that relationship the opportunity to join the ICO's Provider Network.
3. Describe how the Respondent will ensure that new Enrollees will be able to maintain services and providers who may be out of network during the 90-day transition period.

C. Assessment

The Respondent shall:

1. Describe its process for conducting an in-person comprehensive assessment within 90 days of enrollment that includes medical, functional and Behavioral Health needs. This description shall include:
   - How it will ensure that the assessment includes a face-to-face interview with the Enrollee and any other people identified by the Enrollee;
   - How IL-LTSS Coordinators, Behavioral Health clinicians and Care Coordinators will be involved in the assessment, and how they will interface with the Enrollees' PCPs;

- The process to obtain Enrollee consent to review all available medical records for the Enrollee, or other relevant records such as those from State agencies;
- How it will determine situations in which home-based assessments will be offered;
- A copy of a draft assessment tool that assesses:
    - Immediate needs and current services
    - Health conditions and current medications;
    - Functional Status that includes the Enrollee's strengths and barriers;
    - Mental health and substance use conditions;
    - Accessibility requirements (including communication needs, need for transfer equipment, need for personal assistance, need for appointments at a particular time of day),
    - Transportation access;
    - Equipment needs including DME and assistive technology;
    - Housing/home environment;
    - Employment status and interest;
    - Involvement with other care coordinators, care teams, or other state agencies;
    - Social supports;
    - Cultural, linguistic and ethnic identification;
    - Food security and nutrition;
    - Wellness and exercise;
    - Advance directives/guardianship; and
    - Personal goals.
- How it will ensure that Enrollees are prepared to participate in the assessment process.

2. For individuals using or needing LTSS or Behavioral Health services, describe the plan for assessing, as appropriate:
    - The Enrollee's interest in and understanding of self-directed supports;
    - The Enrollee's expressed goals for services/treatment;
    - The Enrollee's preferences regarding privacy, services, formal or informal caregivers, and daily routine;
    - The Enrollee's preferred living situation and a risk assessment for the stability of housing;

- Risk factors for abuse and neglect in the Enrollee's personal life to ensure safety without compromising the Enrollee's autonomy;
- The Enrollee's understanding of his/her rights and responsibilities, including responsibilities associated with self-direction of his/her care.

3. Describe any modifications that will be made to the assessment for Enrollees residing in skilled nursing facilities or other Institution settings, including assessment of factors related to planning the Enrollee's transition to the community, as appropriate.
4. Describe how many new Enrollees the ICO will be able to assess monthly and how that number was determined.

D. Individualized Care Plan (ICP)

The Respondent shall:

1. Describe its plan to ensure that each Enrollee has a meaningful opportunity to participate in the initial development of, and updating of, his/her ICP, including how the Enrollee will receive clear explanations of:
   - His/her health conditions and functional limitations;
   - Available treatment options, needed specialists and coordination between the Primary Care Provider and specialists, social supports and/or alternative courses of care;
   - How family members and social supports can be involved in the care planning as the Enrollee chooses;
   - Self-directed care options and assistance available to self-direct care, if relevant;
   - Services that have a recovery orientation, if relevant;
   - Opportunities for educational and vocational activities;
   - How coordination of care across providers, types of care, care settings and LTSS will be accomplished; and
   - How Enrollees will be informed of their rights regarding what PHI is shared and with whom and how the Respondent will ensure that the Enrollees' preferences are supported to the extent possible.
2. Describe the process that will be used to perform ongoing assessments of each Enrollee and to update the ICP at least annually.
3. Describe the process for transitioning Enrollees to new providers, if needed, once the ICP is completed and signed.

E. IL-LTSS Coordinators

The Respondent shall describe its process for procuring, training and working with IL-LTSS Coordinators, including descriptions of:

1. The Community-Based Organizations with which it will subcontract to provide IL-LTSS Coordinators for each of the core populations who may need LTSS (including adults with physical disabilities, Developmental Disabilities, Serious Mental Illness, and/or substance use disorders, and adults with disabilities who are homeless);
2. How it will ensure that the plan for contracting with IL-LTSS Coordinators includes cross-disability expertise or expertise in all of the disabilities experienced by Enrollees. This includes knowledge and expertise in the provision of services to people who are Deaf or hard of hearing, and/or blind/visually impaired. The ICO will provide copies of any subcontracts already in place;
3. How it will ensure that the IL-LTSS Coordinators have a recovery and independent living orientation;
4. The qualifications and role of the IL-LTSS Coordinator, including the job description;
5. Details regarding the role the IL-LTSS Coordinators will play in communicating and coordinating with providers and/or State agencies currently or previously involved with the Enrollee;
6. A description of the training on the requirements of the ADA and Section 504, what other training will be provided to the IL-LTSS Coordinators and by whom;
7. Who in the ICO or ICT will oversee the work of IL-LTSS Coordinators and how this person will interact with the IL-LTSS Coordinator's employer (the CBO) to ensure smooth ongoing operations, and the process to change the IL-LTSS Coordinator if different expertise is needed or the Enrollee prefers a change;
8. How the competency and work performance of the IL-LTSS Coordinator will be assessed;
9. How IL-LTSS Coordinators will be incorporated into the ICTs;
10. How it will ensure that IL-LTSS Coordinators are present at every initial assessment and available on an ongoing basis as needed; and
11. The projected caseload for each IL-LTSS Coordinator.

F. Interdisciplinary Care Team (ICT)

The Respondent shall:

1. Describe how the ICO will provide access to an ICT for each Enrollee to integrate and coordinate his or her care, including:
    a. How the ICO will ensure that Primary Care Providers assemble and convene ICTs that include all required personnel (see **Section 4.6.B.1**) and other personnel necessary to support person-centered care planning consistent with the Enrollee's needs and at his or her discretion (see **Section 4.6.B.2**); and

b. How the ICO will ensure that Primary Care Providers can support communication among members on the ICTs, including meetings (telephonic and/or in person) as necessary.

2. Describe its plan for training ICT members in person-centered planning, Cultural Competence, Trauma-Informed Care, accessibility and accommodations, independent living and recovery philosophy and wellness principles. Include a description of who will provide the training, their qualifications, how it will be delivered, and the duration and contents of this training.

Section 10.6 Flexible Services and Integration

A. Flexible Services

The Respondent shall:

1. Describe its plan to use non-medical staff (e.g., Community Health Workers and/or qualified peer specialists) to best ensure that Enrollees are supported in living independently in the community, maintain or improve their health and avoid unnecessary hospitalizations or service duplications. The description must include:
   - How it will contract for or hire staff to provide such services;
   - How non-medical staff will be supervised;
   - How it will use non-medical staff; and
   - What training, qualifications, and/or certification it will require and what it will provide for non-medical staff performing these functions.
2. Describe the training on the requirements of the ADA and Section 504, what other training will be provided to the Community Health Workers, and by whom.
3. Describe its plan to use ICO services to support chronically homeless individuals and their successful transition to permanent housing. Consistent with the Housing First approach, describe how the ICO will establish effective linkages with organizations concerned with housing and homelessness to support these Enrollees.
4. Describe its plan to monitor the use, cost and effectiveness (outcomes) of flexible services.
5. Describe its plan to provide Community Support Services as alternatives to costly acute and long-term institutional services, including: 1) day services; 2) home care services; 3) respite care; 4) peer support; 5) care transitions across settings; 6) home modifications; 7) medication management; and 8) non-medical transportation. This description shall include the following, for each service the Respondent anticipates offering:
   - The process for determining when flexible services will be authorized for the advancement of wellness, recovery, self-management of chronic conditions, or independent living; and

- Provide at least two examples where the Respondent has covered a substitute service in lieu of a more costly covered service to improve care for an individual with a disability or improve a provider network in the delivery of services. Describe how the determination was made to cover the service, and outcomes for the Member, if known. A real example is preferred; however, a hypothetical can substitute if a real example is not available.

6. Describe its plan to monitor the use, cost and effectiveness (outcomes) of flexible services.

B. Service Integration

The Respondent shall:

1. Describe its plan to integrate Primary Care and Behavioral Health services.
2. Describe its plan to manage Covered Services in an integrated manner across the continuum of acute, Behavioral Health and long-term services and supports. Provide two specific examples of how the Respondent has integrated care in the past and any documented results of this service integration.
3. Provide examples of how Respondent will implement policies, procedures and staffing or contracts to ensure more appropriate care transitions. Describe transitions between acute, rehabilitation, psychiatric and skilled nursing facilities; between these facilities and community living settings; and between homeless shelters, institutional settings and residential settings. Describe how the Respondent will participate in and ensure appropriate discharge planning.
4. Describe how the Respondent will ensure that it is aware of hospitalizations within 24 hours of an admission.
5. Describe the role of qualified peers or IL-LTSS Coordinators in supporting and facilitating transitions.
6. Describe indicators or performance measures the Respondent will use to demonstrate service integration.

Section 10.7 Coverage Rules and Service Authorization

A. Coverage Rules

The Respondent shall:

1. Submit its Medical Necessity guidelines, program specifications and service components for Behavioral Health services.
2. Describe how it will implement expanded benefits described in **Section 4.2.E** through **4.2.H** to best meet the needs of Enrollees.

B. Service Authorization

The Respondent shall:

1. Describe how it will conduct utilization management activities to promote integration and coordination across services.
2. Describe how it will conduct utilization management activities, including prior authorization and any other benefit management activities. Include a description of service authorization procedures and resources, both technological and personnel.
3. Describe what expertise will be used to assess PCA needs, how the ICO will utilize existing PCM Agencies and what authorization rules will be used in providing care.
4. Describe how it will manage outpatient services utilization, including service authorization procedures, and the resources, both technology and staff, with which the Respondent would support its approach.
5. Describe how it will manage Behavioral Health Diversionary Service utilization, including service authorization procedures, and the resources, both technical and staff, with which the Respondent would support its approach.

C. Out-of-Network Providers

The Respondent shall describe when and how it will authorize and arrange for services provided by non-network providers:

1. When it does not have the capacity to meet the need(s) of the Enrollee to receive Medically Necessary services or necessary LTSS in the benefit package;
2. When it does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers;
3. When transportation or physical access to network providers causes an undue hardship to the Enrollee;
4. For second opinions; and
5. Provide examples where such circumstances have presented themselves in Respondent's prior experience and how they were addressed.

Section 10.8 Alternative Payment Methods

MassHealth strongly encourages the use of Alternative Payment Methodologies in order to support and advance delivery system integration and improvements.

1. The Respondent shall describe how it will use value-based purchasing approaches such as shared savings and shared savings/shared risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and Global Payments in its provider network contracting to encourage the adoption of best practices by provider organizations related to cost containment, quality improvement, and patient protection. The Respondent shall further describe what methodologies it will use to ensure payments to providers are tied to quality of care and outcomes. Contracts using these approaches should include performance-based quality measures with associated financial rewards or penalties, or both.

2. The Respondent shall describe how it will give selected providers financial accountability for the total cost of care using the value-based purchasing strategies described above.
3. The Respondent shall describe how it will support and advance primary care provider adoption of the patient-centered medical home and Health Home models of care.

Section 10.9 Interagency Coordination

A. Departments of Mental Health and Developmental Services

For each agency, the Respondent shall describe how it will establish and maintain linkages with DMH and DDS. Specifically the Respondent shall describe how its care integration activities will involve DMH/DDS, their case managers and their vendors in the treatment, coordination and discharge planning. The Respondent shall also describe its relevant experience working with DMH and DDS.

B. Other State Agencies

The Respondent shall:

1. Describe how it will establish and maintain a relationship with other State agencies that serve a population affected by the ICO (e.g., DPH Bureau of Substance Abuse Services, Elder Affairs, Massachusetts Rehabilitation Commission, Massachusetts Commission for the Blind and Massachusetts Commission for the Deaf and Hard of Hearing).
2. Describe its relevant experience working with other state agencies to promote care integration, and interfacing with agency case managers.

C. Other Agencies and Protected Health Information (PHI)

The Respondent shall describe how it will obtain permission to share information from Enrollees, if such permission is required by law, and to ensure the confidentiality of an individual's protected health information (PHI) in dealings with state agency representatives and their contracted providers.

Section 10.10 Quality Management

A. Performance Monitoring and Improvement

The Respondent shall:

1. Describe its prior experience developing and implementing quality improvement activities for working age adults with disabilities or homeless populations, including any relevant outcomes;
2. Describe its ability to collect data in the proposed domains of measurement as described in **Section 5.7**, and to share quality performance data with providers in formats that support performance improvement;

3. Propose a performance measure focused on service integration across acute and LTSS. Include in the proposal the metric, the specifications, how the respondent will establish the baseline and the improvement target used to measure success; and
4. Propose a performance measure focused on service integration across Primary Care and Behavioral Health. Include in the proposal the metric, the specifications, how the respondent will establish the baseline, and the improvement target used to measure success.

B. Quality Management Program

1. The Respondent shall describe its QM philosophy/mission statement and the key aspects of its QM system including organization chart(s) and staffing plan. Description should include:
    a. How the Respondent will integrate quality management across all of its responsibilities under the Contract, with particular focus on Network Management, Utilization Management, and Member and Provider Services;
    b. How its approach to Quality Management will help to identify, address and overcome barriers, causes, and systemic problems that would otherwise lead to fragmented service delivery;
    c. Its experience with standardized tools used to measure health outcomes, including examples of specific tools it has used, and why;
    d. How QM activities will support and improve integration of care between Primary and specialty Providers including Behavioral Health, and what incentives, if any, the Respondent proposes to utilize to increase these interactions;
    e. The Respondent's experience collecting and reporting on quality indicators, such as HEDIS, and using data-driven indicators to monitor and improve the quality of medical services, Behavioral Health services, and care management activities. Include examples and results, if known; and
    f. The role that quality measures will play in its financial arrangements with providers with whom it uses Alternative Payment Methodologies.
2. Propose a performance measure focused on service integration to increase the percentage of ICO Plan Enrollees with significant Behavioral Health needs who are appropriately engaged in all aspects of preventive Primary Care, including Primary Care visits and other specialty care as indicated. Include proposed metrics and specifications that would be used to establish the baseline and the improvement target to measure success.

Section 10.11 Enrollee Services

The Respondent shall:

A. Describe its proposed Enrollee services department and functions. The Respondent shall note whether the proposed Enrollee services department will be dedicated to the Contract or whether it is a shared function with other public or commercial programs. If shared, the Respondent shall describe how it will ensure that the Respondent will dedicate the necessary resources to ensure compliance with all of the terms of the Contract.

B. Describe in detail the Respondent's proposed telephone system and staffing for Enrollee services including, but not limited to, the following:

1. TTY capabilities, access to ASL interpreter services, text support for cell phone or internet-based communication;
2. Hours of operation;
3. Staff's multilingual and multicultural capability;
4. Staff's ability to assist Enrollees who have communication challenges related to a disability;
5. Proposed number of Enrollee services staff expressed in full time employees (FTEs) per 200 Enrollees, during the hours of 8:00 a.m. to 5:00 p.m., local time in the Service Area, Monday through Friday, excluding state-approved holidays. If this is a shared function, the Respondent shall provide proposed staffing that reflect the total number of individuals served, not limited to Enrollees under the Contract;
6. Routing of calls among hotline staff to ensure timely and accurate response to Enrollee inquiries;
7. After-hours procedures and services for providers including procedures for verifying enrollment:
    a. Enrollee services, including services provided to non-English-speaking Enrollees;
    b. Routing of Emergency Services requests appropriately to Emergency Services Providers; and
    c. Provider services, including procedures for verifying enrollment.
8. Responsibilities of Enrollee services staff, if any, in addition to responding to Enrollee calls (e.g., responding to non-MassHealth Enrollee calls, responding to provider calls, etc.).

C. Describe any proposed system redundancies or workarounds to ensure that access is not disrupted during a telephone service outage;

D. Describe its proposed approach to providing education to Enrollees and family members about how to use Covered Services and supports as an alternative to emergency department visits, when appropriate;

E. Describe its plan to provide training in cross-disability awareness, self-direction, recovery models, LTSS, and communication skills to ensure that Enrollee services staff can provide disability-competent services to Enrollees;

F. Describe its plan to provide relevant Enrollee information on the Web or in Alternative Formats;

G. Submit samples of materials prepared by the Respondent for MassHealth populations (if available) or other educational materials intended for broad distribution to Enrollees, including materials addressing services that may be provided by a Material Subcontractor, such as home or community-based Long-Term Services and Supports; and

H. Describe its proposed 24/7 on-call response capabilities for Enrollees, which must include: (i) the availability of a live person to answer Enrollee calls on a 24-hour, seven-day-per-week basis; (ii) on-call response capabilities that can address any Enrollee needs for urgent or emergency medical care or supports, and (iii) compliance with the Americans with Disabilities Act's requirements for effective communication with the disabled. The description must include the proposed telephone system, staffing patterns, multilingual capabilities of staff, supervision and emergency procedures. Such description must also include the following:

1. Staff credentials (include clinical back-up available);
2. Organization chart of staff;
3. Flow chart of telephone triage system; and
4. Description of procedures to address urgent medical care or support needs of Enrollees.

Section 10.12 Grievance and Appeals Processes

The Respondent shall describe how it proposes to provide a process for addressing Grievances and Appeals under the Contract, as described in **Section 5.1**.

Section 10.13 Consumer Input

The Respondent shall describe how it will meet the requirements stated in **Section 5.5**, including:

A. How it will establish one or more Consumer advisory committees that include persons participating in this Demonstration, and what procedures will be established for that committee to provide input to the ICO; and

B. How it will arrange for participation of Consumers with disabilities, including Enrollees, within the governance structure of the ICO.

SECTION 11. RESPONSE EVALUATION PROCESS

Section 11.1 CMS Application Process

The outcome of this procurement will be a three-way contract between CMS, EOHHS, and organizations selected to participate in the Demonstration as ICOs. CMS has issued instructions about their qualification process for organizations seeking to participate in Duals Demonstrations, including CMS's January 25, 2012 *Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans*; March 29, *2012 Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans in 2013*; other guidance documents, and the *2013 Capitated Financial Alignment Demonstration Application*.[2] Respondents must meet all CMS requirements for selection in order to be considered for selection in this procurement.

Section 11.2 Evaluation Committee

Responses submitted pursuant to this RFR will be evaluated by an Evaluation Committee (the Committee; also referred to as the Procurement Management Team, or PMT) appointed by EOHHS.

Section 11.3 Response Review Process and Evaluation Criteria

A. Response Review

Respondents to this RFR must meet all the CMS Capitated Financial Alignment (CFA) Demonstration Plan Application requirements, including for Part D. In addition, all responses shall be initially reviewed to determine compliance with the response submission instructions (**Section 8**) and the Business Response requirements (**Section 9**). Responses that meet those requirements shall have their Programmatic Responses (**Section 10**) reviewed and evaluated by the Committee.

B. Programmatic Response Review Evaluation Criteria

EOHHS will: (1) evaluate Programmatic Responses by giving a composite rating of "Excellent," "Very Good," "Good," "Fair," "Poor" or "Non-Responsive" for each section evaluated; (2) assign each of the responses an overall rating; (3) compare the responses; and (4) rank the responses in order of preference, if necessary due to the number of proposals in any county. The following identifies, in descending order of importance, the criteria by which EOHHS will evaluate each response for selection as an ICO on a county-by-county basis:

1. the quality of the responses to the questions in **Section 10** in accordance with the following criteria: comprehensiveness, feasibility, appropriateness, clarity,

[2] For all capitated model demonstrations with 2013, effective enrollment dates, CMS has extended the timeline for prospective integrated entities to submit MOCs via HPMS. The original requirement was for integrated entities to submit their MOCs by May 24, 2012, as part of their Demonstration Applications to CMS. That date has been extended, and the new deadline will be shared with integrated entities via HPMS.

effectiveness, innovation, and responsiveness to the needs of EOHHS and the goals of the Duals Demonstration;

2. the Respondent's understanding of the population to be served through the Duals Demonstration;
3. the Respondent's proposed service delivery innovations, including the use of flexible benefits;
4. the Respondent's proposed use of Alternative Payment Methodologies;
5. the extent to which the Respondent's network of providers offers Demonstration Enrollees more choices of providers than required to comply with CMS (Medicare) network adequacy standards, or network adequacy standards established by EOHHS;
6. the extent to which the Respondent demonstrates that its pharmacy formulary exceeds the minimum required to participate as a Medicare Part D Plan. EOHHS may prefer Respondents that provide Duals Demonstration Enrollees with formularies that provide the most breadth and depth, as determined by EOHHS, subject to medical necessity (including the availability of appropriate least costly alternatives, such as generic alternatives);
7. the extent to which the Respondent demonstrates that it has lower cost-sharing requirements than the maximum permitted. EOHHS may prefer Respondents that have lower cost sharing requirements; and
8. the extent to which the Respondent's service area includes full counties rather than partial counties.

C. Supplier Diversity Plan

All Respondents must follow the requirements set forth in the Supplier Diversity Program (SDP) section of the RFR (**Section 13.17**), which requires Respondents to develop creative initiatives to help foster new business relationships with Minority/Women Business Enterprises (M/WBE) within the primary industries affected by this RFR. In order to satisfy compliance with this section and encourage respondents' participation in SDP objectives, the SDP Plan will be evaluated as a percentage of the total evaluation.

D. Oral Presentation

The Committee, in its sole discretion, may invite those Respondents whose responses have been judged competitive and responsive in the course of the evaluation to attend an Oral Presentation. At that time, the Respondent's proposal may be discussed and clarified, but not changed or corrected in any way. The Committee reserves the right to apply restrictions to the structure and content of the Oral Presentation, and to instruct the Respondent regarding attendees. The Committee shall schedule the time and location of any oral presentation.

Oral presentations shall not be open to the public nor to any competitors. Failure of a Respondent to agree to a date and time for an oral presentation may result in rejection of the Respondent's proposal.

E. Site Visits and Finalist Interviews

The Committee, in its sole discretion, and at its convenience, may elect to inspect any Respondent's offices. An inspection would most likely consist of a detailed introduction to the Respondent's operations that are relevant to this RFR. Failure to agree to such an inspection may result in rejection of the Respondent's proposal.

Respondents selected as finalists may be also required to participate in an interview at EOHHS's Central Office. The interview is intended to:

1. Clarify and substantiate representations and information contained in the Respondent's proposal;
2. Supplement information obtained in the Respondent's proposal;
3. Provide additional understanding of the services and operations offered and any additional information requested; and
4. Introduce all key personnel [and any Material Subcontractors] who will have responsibility for Contract responsibilities.

F. Past Performance

The Committee, in its sole discretion, will consider in its review process past performance in programs administered by CMS and EOHHS, and any corrective actions or restrictions imposed by CMS or EOHHS.

G. Best and Final Offer

Each response should be submitted on the most favorable terms the Respondent can offer. However, EOHHS reserves the right to request best and final offers from any Respondent.

H. Recommendation for Award

1. General

   After the Committee completes its evaluation, comparison, and ranking, if necessary due to the number of proposals in any county, of all proposals, and, if applicable, oral presentation(s) and site visit(s), the Committee will recommend to the Medicaid Director or his designee, the Respondents with which to enter into contract negotiations. The Medicaid Director's decision shall be based on the Committee's recommendation and on the best interests of the Commonwealth.

2. County-Based Awards

a. All Contract awards shall be by county. A Respondent may be awarded a contract in all, some, or none of the counties for which it submitted a proposal. No more than five awards will be made per county.

b. Respondents shall accept Contract awards in all counties for which they are selected whether or not they are selected for each county for which they bid.

I. Negotiation

EOHHS, in its sole discretion, may negotiate with a selected Respondent a change in any element of Contract performance or cost identified in the original RFR, or the selected Respondent's response, that results in lower costs or a more cost-effective or better value than was presented in the selected Respondent's original response. The Contract award shall be contingent upon successful negotiation of contract terms. Should EOHHS and any selected Respondent fail to reach an agreement on Contract terms, EOHHS, in its sole discretion, may negotiate with and award a Contract to any other Respondent it selects.

Section 11.4 Non-Qualifying Proposals

A. Rejection of Responses

A Respondent's response may be rejected at any time during the evaluation process if the Respondent:

1. Fails to meet the requirements of the CMS CFA Demonstration Application;
2. Fails to demonstrate to EOHHS's satisfaction that it meets all RFR requirements;
3. Fails to demonstrate that it has met the applicable standard for financial solvency
4. Fails to satisfy all Response Submission Instructions described in **Section 8**;
5. Fails to submit all required information and to otherwise comply with all requirements of the Business Specifications described in **Section 9**;
6. Fails to respond to any question in the Programmatic Response requirement described in **Section 10**;
7. Fails to submit a response organized in accordance with all instructions;
8. Fails to submit a response that is complete in all respects;
9. Receives a rating of "Poor" or "Non-Responsive" in the evaluation of one or more categories of the respondent's Programmatic Response;
10. Has any interest that may, in EOHHS's sole determination, conflict with performance of services for the Commonwealth or is otherwise anti-competitive;
11. Fails to demonstrate to EOHHS's satisfaction that it, and all Material Subcontractors, are in sound financial condition;
12. Fails to make an oral presentation requested by EOHHS at a time, place, and manner satisfactory to EOHHS;

13. Fails to reach an agreement with EOHHS on all Contract terms; or

14. Fails to accept the terms of the reimbursement provisions.

B. Option to Allow Partial Resubmission

Notwithstanding **Section 11.4.A.9** above, where the Committee's evaluation shows that a Respondent's proposal received a poor rating in not more than one category, but was submitted by a Respondent proposing to serve a county where EOHHS determines there may be insufficient access, EOHHS may opt to, but is not required to, provide to so-evaluated Respondent one opportunity to resubmit only that portion(s) of the proposal which EOHHS initially determined unsatisfactory. If EOHHS elects to exercise this option, it shall provide said resubmission opportunity to all so-evaluated Respondents, shall identify and describe the nature of the deficiencies in each so-evaluated Respondent's proposal, and shall allow each such Respondent the same amount of time to resubmit the affected section of its proposal. Such resubmitted proposal components shall be evaluated in the same manner as original proposals.

C. Other Remedies

The Committee, in its sole discretion, may determine that non-compliance with any RFR requirement is insubstantial. In such cases, the Committee may:

1. Seek clarification;
2. Allow the Respondent to make minor corrections;
3. Apply appropriate penalties in the evaluation; or
4. Apply a combination of all three remedies.

SECTION 12. PROCUREMENT TIMETABLE

1.	RFR issued:	June 18, 2012
2.	Respondents' Conference (See **Section 13.8**):	June 25, 2012 2:00 p.m.-4:00 p.m. (EDT)
3.	Written Inquiries Due (See **Section 13.7**):	4:00 p.m. (EDT) July 6, 2012
5.	**Respondents' Responses Due**	**4:00 p.m. (EDT) July 30, 2012**
6.	Anticipated Date for Selection Announcement:	August 31, 2012
7.	Anticipated Contract Execution Date:	December 15, 2012
8.	Anticipated Service Start Date:	April 1, 2013

SECTION 13. RFR INFORMATION

Section 13.1 Issuing Office

Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

Section 13.2 Requirements of 801 CMR 21.00

The terms of 801 CMR 21.00: Procurement of Commodities and Services are incorporated by reference into this RFR. Words used in this RFR shall have the meanings defined in 801 CMR 21.00. Additional definitions may also be identified in this RFR. Unless otherwise specified in this RFR, all communications, responses, and documentation must be in English, all measurements must be provided in miles, feet, inches, and pounds and all cost proposals or figures in U.S. currency. All responses must be submitted in accordance with the specific terms of this RFR.

Section 13.3 Comm-PASS

Comm-PASS. Comm-PASS is the official system of record for all procurement information which is publicly accessible at no charge at www.comm-pass.com. Information contained in this document and in each tab of the Solicitation, including file attachments, and information contained in the related Respondents' Forum(s), are all components of the solicitation.

Respondents are solely responsible for obtaining all information distributed for this Solicitation via Comm-PASS, by using the free Browse and Search tools offered on each record-related tab on the main navigation bar (Solicitations and Forums). Forums support Respondent submission of written questions associated with a Solicitation and publication of official answers. All records on Comm-PASS are comprised of multiple tabs, or pages. For example, Solicitation records contain Summary, Rules, Issuer(s), Intent or Forms & Terms and Specifications, and Other Information tabs. Each tab contains data and/or file attachments provided by the Procurement Management Team. All are incorporated into the Solicitation.

It is each Respondent's responsibility to check Comm-PASS for:

- Any addenda or modifications to this Solicitation, by monitoring the "Last Change" field on the Solicitation's Summary tab, and
- Any Respondents' Forum records related to this Solicitation (see Locating an Online Respondents' Forum for information on locating these records).

The Commonwealth accepts no responsibility and will provide no accommodation to Respondents who submit a Response based on an out-of-date solicitation or on information received from a source other than Comm-PASS.

Comm-PASS SmartBid Subscription. Respondents may elect to obtain an optional SmartBid subscription which provides value-added features, including automated email notification associated with postings and modifications to Comm-PASS records. When properly configured and managed, SmartBid provides a subscriber with:

- A secure desktop within Comm-PASS for efficient record management;
- A customizable profile reflecting the subscriber's product/service areas of interest;
- A customizable listing in the publicly accessible Business Directory, an online "yellow-pages" advertisement;
- Full-cycle, automated email alert whenever any record of interest is posted or updated; and
- Access to Online Response Submission, when allowed by the Issuer, to support:
    - paperless bid drafting and submission to an encrypted lock-box prior to close date
    - electronic signature of OSD forms and terms; agreement to defer wet-ink signature until Contract award, if any
    - withdrawal of submitted bids prior to close date
    - online storage of submitted bids.

Every public purchasing entity within the borders of Massachusetts may post records on Comm-PASS at no charge. Comm-PASS has the potential to become the sole site for all public entities in Massachusetts. SmartBid fees are only based on and expended for costs to operate, maintain and develop the Comm-PASS system.

Section 13.4 Respondent Communications

Respondents are prohibited from communicating directly with any employee of EOHHS regarding this RFR, except as specified in this RFR, and no other individual Commonwealth employee or representative is authorized to provide any information or respond to any question or inquiry concerning this RFR. Respondents may contact the contact person for this RFR in the event this RFR is incomplete or the Respondent is having trouble obtaining any required attachments electronically through Comm-PASS.

Electronic Communication/Update of Respondent's/ICO's Contact Information. It is the responsibility of the prospective Respondent and contracted ICO to keep current the e-mail address of the Respondent's contact person and prospective Contract Manager, if awarded a Contract, and to monitor that e-mail inbox for communications from the Procurement Management Team (PMT), including requests for clarification. The PMT and the Commonwealth assume no responsibility if a prospective Respondent's/contracted ICO's designated email address is not current, or if technical problems, including those with the prospective Respondent's/contracted ICO's computer, network or internet service provider (ISP) cause email communications sent to/from the prospective Respondent/contracted ICO and the PMT to be lost or rejected by any means including email or spam filtering.

Section 13.5 Reasonable Accommodation

Respondents with disabilities or hardships who seek reasonable accommodation, which may include the receipt of RFR information in an Alternative Format, must communicate such requests in writing to the contact person. Requests for accommodation will be addressed on a case-by-case basis. A Respondent requesting accommodation must submit a written statement that describes the Respondent's disability and the requested accommodation to the contact person for the RFR. EOHHS reserves the right to reject unreasonable requests.

Section 13.6 RFR Copies

Respondents should download all RFR documents from Comm-PASS. If necessary, Respondents may request a copy of the RFR, or any of its components, by contacting Ms. Geraldine Sobkowicz through any of the following methods:

- in writing at the Issuing Office specified in **Section 13.1** above or at geraldine.sobkowicz@state.ma.us;
- by fax to (617) 573-1893; or
- by telephone at (617) 573-1678

Section 13.7 RFR Inquiries

Respondents may make written inquiries concerning this RFR until no later than the date and time specified in the timetable in **Section 12**. Written inquiries must be sent to Ms. Sobkowicz at the address listed in **Section 8.4**, or at the e-mail or fax number listed above in **Section 13.6**.

Inquiries received after the deadline may be disregarded. EOHHS will review inquiries received before the deadline, and at its discretion, prepare written responses to questions which EOHHS determines to be of general interest. Any written response will be made available to all identified prospective Respondents. Only written responses will be binding on EOHHS.

EOHHS could in its sole judgment determine, as a result of Respondent inquiries or significant changes made to the RFR, that additional opportunities for written inquiries would be beneficial to Respondents. In that case, EOHHS will announce a new deadline for Respondents to submit additional questions. And follow the same protocols as described above. Only written responses will be binding on EOHHS.

Section 13.8 Respondents' Conference

Prospective Respondents are invited to attend a Respondents' Conference, to be held:

DATE: Monday, June 25, 2012

TIME: 2:00 p.m. – 4:00 p.m. (EDT)

LOCATION: State Transportation Building, 10 Park Plaza, Conference Rooms 1, 2 and 3, Boston, MA 02116

(Public transportation: Chinatown stop on the Orange Line; Boylston stop on the Green Line; Park St. stop on Red Line)

At this meeting EOHHS will entertain questions regarding the RFR and the evaluation process. Oral responses will be given when possible. Written responses will be prepared as determined appropriate by EOHHS and posted on Comm-PASS. Only written responses will be binding on EOHHS.

Section 13.9 Addendum or Withdrawal of RFR

If EOHHS decides to amend or clarify any part of this RFR, any written amendment will be posted on Comm-PASS and provided to all identified prospective Respondents. EOHHS reserves the right to amend the RFR at any time prior to the deadline for submission of responses and to terminate this procurement in whole or in part at any time

Section 13.10 Costs

Costs which are not specifically identified in the Respondent's response, and accepted by EOHHS as part of a contract, will not be compensated under any contract awarded pursuant to this RFR. The Commonwealth will not be responsible for any costs or expenses incurred by Respondents responding to this RFR.

Section 13.11 Closing Date

Responses received after the response due date and time specified in the timetable in **Section 12** will be rejected. Individual requests for extension of the time for submitting responses will be denied. All responses become the property of the Commonwealth of Massachusetts.

Section 13.12 Acceptance of Response Content

The entire contents of the Respondent's response shall be binding on the Respondent. The specifications and contents of a successful Respondent's response may be incorporated into the Contract.

Section 13.13 Public Records

All responses and related documents submitted in response to this RFR are public records and are subject to the Massachusetts Public Records Law, M.G.L. c. 66, § 10 and M.G.L. c. 4, § 7 subsection 26. Any statements in submitted responses that are inconsistent with these statutes will be disregarded.

Section 13.14 Response Duration

The Respondent's response shall remain in effect until any Contract with the Respondent is executed.

Section 13.15 Contract Term and Termination

Any Contract awarded under this RFR is anticipated to be for a period of three years scheduled to commence on April 1, 2013, and end on December 31, 2016.

In addition to termination for cause, the Contract may be terminated if: (1) if the Respondent does not accept EOHHS's rate offer each year; (2) the implementation of the Accountable Care Act or other state or federal health care reform initiatives or state or federal health care cost containment legislation makes termination of the Contract necessary or advisable, as determined by EOHHS, or (3) CMS or EOHHS elects not to continue the Demonstration at any time, including in accordance with section 1115A(b)(3)(B), with 90 days' notice to ICOs.

Section 13.16 Compliance

The ICO must comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended.

Section 13.17 Supplier Diversity Plan

Massachusetts Executive Order 524 established a policy to promote the award of state contracts in a manner that develops and strengthens Minority and Women Business Enterprises (M/WBEs) that resulted in the Supplier Diversity Program in Public Contracting. M/WBEs are strongly encouraged to submit responses to this RFR, either as prime vendors, joint venture partners or other type of business partnerships. All bidders must follow the requirements set forth in the SDP section of the RFR, which will detail the specific requirements relating to the prime vendor's inclusion of M/WBEs. Bidders are required to develop creative initiatives to help foster new business relationships with M/WBEs within the primary industries affected by this RFR. In order to satisfy the compliance of this section and encourage bidder's participation of SDP objectives, the Supplier Diversity Program (SDP) Plan for large procurements greater than $150,000 will be evaluated at 10% or more of the total evaluation. Once an SDP Plan is submitted, negotiated and approved, the agency will then monitor the contractor's performance, and use actual expenditures with SDO certified contractors to fulfill their own SDP expenditure benchmarks. M/WBE participation must be incorporated into and monitored for all types of procurements regardless of size; however, submission of an SDP Plan is mandated only for large procurements over $150,000.

This RFR will contain some or all of the following components as part of the Supplier Diversity Program Plan submitted by bidders:

- Subcontracting with certified M/WBE firms as defined within the scope of the RFR,
- Ancillary use of certified M/WBE firms,
- Growth and Development activities to increase M/WBE capacity.

A Minority Business Enterprise (MBE), Woman Business Enterprise (WBE), M/Non-Profit, or W/Non-Profit, is defined as such by the Supplier Diversity Office (SDO). All certified businesses that are included in the bidder's SDP proposal are required to submit an up to date copy of their SDO certification letter. The purpose for this certification is to participate in the Commonwealth's Supplier Diversity Program for public contracting. Minority- and Women-Owned firms that are not currently certified but would like to be considered as an M/WBE for the purpose of this RFR should submit their application at least two weeks prior to the RFR closing date and submit proof of documentation of application for consideration with their bid proposal. For further information on SDO certification, contact their office at 1-617-502-8851 or via the Internet at mass.gov/SDO.

Supplier Diversity Program Subcontracting Policies. Prior approval of the agency is required for any subcontracted service of the Contract. Agencies may define required deliverables including, but not limited to, documentation necessary to verify subcontractor commitments and expenditures with Minority- or Women-Owned Business Enterprises (M/WBEs) for the purpose of monitoring and enforcing compliance of subcontracting commitments made in a bidder's Supplier Diversity Program (SDP) Plan. Contractors are responsible for the satisfactory performance and adequate oversight of its subcontractors.

Section 13.18 Confidentiality

The selected Respondent shall comply with all state and federal laws and regulations relating to confidentiality and privacy, including, but not limited to, rules and regulations of EOHHS. Each Respondent agrees and accepts that it is a Covered Entity pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R, parts 160 and 164.

EOHHS may require specific written assurance and further agreements regarding the security and privacy of protected health information that are deemed necessary to implement and comply with standards under HIPAA. .

Section 13.19 Incorporation of RFR

This RFR and all response documents submitted in response to it by a selected Respondent may, at EOHHS's discretion, be incorporated by reference into any Contract awarded as a result of this RFR to that Respondent.

Section 13.20 Debriefing

Upon notification of EOHHS's award decision, any non-selected Respondent may make a written request for debriefing. A debriefing meeting provides the Respondent an

opportunity to discuss the evaluation of its response, identify any weak areas and suggest improvements for future procurements. A request for debriefing must be received by EOHHS at the Issuing Office specified in **Section 13.1**, within 14 calendar days after the postmark of EOHHS's award decision notification to the Respondent. Debriefing meetings shall be held at the discretion of EOHHS.

Section 13.21 Authorizations and Appropriations

Any contract awarded under this RFR is subject to all necessary federal and state approvals, as applicable, and is subject to appropriation of sufficient funding, as determined by EOHHS.

Section 13.22 Subcontracting

Prior approval of EOHHS is required for any Material Subcontractor's service under the Contract. ICOs are responsible for the satisfactory performance and adequate oversight of its subcontractors. Human and social service subcontractors are also required to meet the same state and federal financial and program reporting requirements and are held to the same reimbursable cost standards as contractors.

Section 13.23 Byrd Anti-Lobbying Amendment

If a Contractor receives $100,000 or more of federal funds through a contract, by signing that contract it certifies it has not and will not use federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. § 1352. A Contractor shall disclose any lobbying with non-federal funds that takes place in connection with obtaining any federal award.

Section 13.24 Pricing

The Respondent must agree that no other state or public entity customer within the United States of similar size and with similar terms and conditions shall receive a lower price for the same commodity and service during the Contract period, unless this same lower price is immediately effective for the Commonwealth. If the Commonwealth believes that it is not receiving this lower price as required by this language, the Respondent must agree to provide current or historical pricing offered or negotiated with other state or public entities at any time during the Contract period in the absence of proprietary information being part of such Contracts.

Section 13.25 Electronic Funds Transfer

All Respondents responding to this RFR must agree to participate in the Commonwealth Electronic Funds Transfer (EFT) program for receiving payments, unless the Respondent can provide compelling proof that it would be unduly burdensome. EFT is a benefit to both contractors and the Commonwealth because it ensures fast, safe and reliable

payment directly to contractors and saves both parties the cost of processing checks. Contractors are able to track and verify payments made electronically through the Comptroller's Vendor Web system. A link to the EFT application can be found on the OSD Forms page (www.mass.gov/osd). Additional information about EFT is available on the VendorWeb site (www.mass.gov/osc). Click on MASSfinance.

Successful Respondents, upon notification of contract award, will be required to enroll in EFT as a contract requirement by completing and submitting the Authorization for Electronic Funds Payment Form to this department for review, approval and forwarding to the Office of the Comptroller. If the Respondent is already enrolled in the program, it may so indicate in its response. Because the Authorization for Electronic Funds Payment Form contains banking information, this form, and all information contained on this form, shall not be considered a public record and shall not be subject to public disclosure through a public records request.

The requirement to use EFT may be waived by the PMT on a case-by-case basis if participation in the program would be unduly burdensome on the Respondent. If a Respondent is claiming that this requirement is a hardship or unduly burdensome, the specific reason must be documented in its response. The PMT will consider such requests on a case-by-case basis and communicate the findings with the Respondent.

Section 13.26 Environmental Response Submission Compliance

In an effort to promote greater use of recycled and environmentally preferable products and minimize waste, all responses submitted should comply with the following guidelines:

- All copies should be printed double-sided.
- All submittals and copies should be printed on recycled paper with a minimum post-consumer content of 30% or on tree-free paper (i.e., paper made from raw materials other than trees, such as kenaf). To document the use of such paper, a photocopy of the ream cover/wrapper should be included with the response.
- Unless absolutely necessary, all responses and copies should minimize or eliminate use of non-recyclable or non-reusable materials such as plastic report covers, plastic dividers, vinyl sleeves and GBC binding. Three-ringed binders, glued materials, paper clips and staples are acceptable.
- Respondents should submit materials in a format which allows for easy removal and recycling of paper materials.
- Respondents are encouraged to use other products which contain recycled content in their response documents. Such products may include, but are not limited to, folders, binders, paper clips, diskettes, envelopes, boxes, etc. Where appropriate, Respondents should note which products in their responses are made with recycled materials.

- Unnecessary samples, attachments or documents not specifically asked for should not be submitted.

Section 13.27 HIPAA: Business Associate Contractual Obligations

Respondents are notified that EOHHS's operation of MassHealth meets the definition of a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and EOHHS will include in the RFR and resulting contract sufficient language establishing the successful Respondent's contractual obligations that EOHHS will require in order to comply with HIPAA and the privacy and security regulations promulgated thereunder (45 C.F.R. Parts 160, 162, and 164) (the Privacy and Security Rules). A successful Respondent is a business associate performing functions or activities involving protected health information for those portions of the Contract that EOHHS designates, as such terms are used in the Privacy and Security Rules; thus, EOHHS will include in the RFR and resulting contract a sufficient description of business associate's contractual obligations regarding the privacy and security of the protected health information, as listed in 45 C.F.R. §§ 164.314 and 164.504 (e), including, but not limited to, the Respondent's obligation to: implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the protected health information (in whatever form it is maintained or used, including verbal communications); provide individuals access to their records; and strictly limit use and disclosure of the protected health information for only those purposes approved by EOHHS. Further, EOHHS reserves the right to add any requirement during the course of the contract that it determines it must include in the contract in order for EOHHS to comply with the Privacy and Security Rules. Please see other sections of the RFR for any further HIPAA details, if applicable.

Section 13.28 Fraud

The ICO shall notify EOHHS in writing within 10 calendar days if it or, where applicable, any of its subcontractors receive or identify any information that gives them reason to suspect that a MassHealth Provider or Member has engaged in fraud as defined under 42 C.F.R. § 455.2. In the event of suspected fraud, no further contact shall be initiated with the Provider or Member on that specific matter without EOHHS's approval.

The ICO and, where applicable, its subcontractors shall cooperate fully with the Office of the Attorney General's Medicaid Fraud Division (MFD) and the Office of the State Auditor's Bureau of Special Investigations (BSI). Such cooperation shall include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding Medicaid fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

Section 13.29 Restriction on the Use of the Commonwealth Seal

Respondents and ICOs are not allowed to display the Commonwealth of Massachusetts Seal in their bid package or subsequent marketing materials if they are awarded a contract because use of the coat of arms and the Great Seal of the Commonwealth for advertising or commercial purposes is prohibited by law.