FIRST AMENDED AND RESTATED CONTRACT

BY AND BETWEEN

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

LAHEY CLINICAL PERFORMANCE NETWORK, LLC

TO SERVE AS AN

MCO-ADMINISTERED ACCOUNTABLE CARE ORGANIZATION

FOR THE

ACCOUNTABLE CARE ORGANIZATION PROGRAM

This First Amended and Restated Contract is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS") and Lahey Clinical Performance Network, LLC (the "Contractor"), with principal offices located at 41 Mall Road, Burlington, MA, 01805.

WHEREAS, EOHHS oversees 16 state agencies and is the single state agency responsible for the administration of the Medicaid program and the State Children's Health Insurance Program within Massachusetts (collectively, MassHealth) and other health and human services programs designed to pay for medical services for eligible individuals pursuant to M.G.L. c. 118E, Title XIX of the Social Security Act (42 U.S.C. sec. 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. sec. 1397aa et seq.), and other applicable laws and waivers; and

WHEREAS, EOHHS issued a Request for Responses (RFR) for Accountable Care Organizations on September 29, 2016 to solicit responses from Accountable Care Organizations (ACOs), to provide comprehensive health care coverage to MassHealth Members; and

WHEREAS, EOHHS has selected the Contractor, based on the Contractor's response to the RFR, submitted by the deadline for responses, to provide health care coverage to MassHealth Members; and

WHEREAS, EOHHS and the Contractor entered into the Contract effective August 25, 2017, and with an Operational Start Date of March 1, 2018, to improve the MassHealth Member experience of care, health of the population, and efficiency of the MassHealth program by substantially shifting towards accountable and integrated models of care and to provide comprehensive health care coverage to MassHealth Members; and

WHEREAS, EOHHS and the Contractor amended the Contract effective March 1, 2018, (Amendment #1);

WHEREAS, EOHHS and the Contractor amended the Contract effective October 1, 2018, (Amendment #2);

WHEREAS, EOHHS and the Contractor amended the Contract effective March 1, 2018, (Amendment #3);

WHEREAS, in accordance with **Section 5.13** of the Contract, EOHHS and the Contractor desire to amend and restate the Contract effective January 1, 2019; and

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

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

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DEFINITIONS

The following terms appearing capitalized throughout this Contract and its Appendices have the following meanings, unless the context clearly indicates otherwise.

Accountable Care Organizations (ACOs) - certain entities, contracted with EOHHS as accountable care organizations, that enter into population-based payment models with payers, wherein the entities are held financially accountable for the cost and quality of care for an attributed Member population. Entities that enter into Contracts with EOHHS pursuant to the RFR are ACOs.

ACO Certification – the ACO certification process developed by the Massachusetts Health Policy Commission (HPC) pursuant to Section 15 of Chapter 6D of the Massachusetts General Laws, which requires the HPC to establish a process for certain registered provider organizations to be certified as accountable care organizations.

ACO-Eligible Member – a Member who is eligible to enroll in a MassHealth ACO.

ACO/MCO – CP Agreement – a written agreement between the Contractor and a Community Partner that delineates roles and responsibilities, as described in **Appendix G** and **Appendix H**.

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.

Affiliated Hospital – a hospital that has an affiliation with the Contractor for the purposes of this Contract as described in **Section 2.2.C**.

Affiliated Providers – providers that have affiliations with the Contractor for the purposes of this Contract, as described in **Section 2.2**.

Alternative Formats – provision of Attributed Member 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 shall include, but not be limited to, Braille, large font, audio tape, video tape, and information read aloud to an Attributed Member by a member services representative.

Appeals – EOHHS processes for Members to request review of certain actions pursuant to 130 CMR 610.000.

Approved ACO Agreement – a contract between the Contractor and a MassHealth-contracted MCO approved by EOHHS that delineates responsibilities and establishes financial accountability as described in **Section 2.4.**

Attributed Member – a Member who is enrolled with one of the MassHealth-contracted MCOs with which the Contractor has an Approved ACO Agreement and who is assigned by that MCO to one of the Contractor's Participating PCPs.

Attributed Members with Special Health Care Needs – Attributed Members who meet the following characteristics:

A. Have complex or chronic medical needs requiring specialized health care services, including persons with multiple chronic conditions, co-morbidities, and/or co-existing functional impairments, and including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities described below:

   1. Cognitive Disability – a condition that leads to disturbances in brain functions, such as memory, orientation, aware ness, perception, reasoning, and judgment. Many conditions can cause cognitive disabilities, including but not limited to Alzheimer's disease, bipolar disorder, Parkinson disease, traumatic injury, stroke, depression, alcoholism, and chronic fatigue syndrome.

   2. Intellectual Disability – is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior that affect many everyday social and practical skills.

   3. Mobility Disability - an impairment or condition that limits or makes difficult the major life activity of moving a person's body or a portion of his or her body. "Mobility disability" includes, but is not limited to, orthopedic and neuro-motor disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.

   4. Psychiatric Disability – a mental disorder that is a health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Examples include, but are not limited to, depression, bipolar disorder, anxiety disorder, schizophrenia, and addiction.

   5. Sensory Disability - any condition that substantially affects hearing, speech, or vision.

B. Are children/adolescents who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally;

C. Are at high risk for admission/readmission to a 24-hour level of care within the next six months;

D. Are at high risk of institutionalization;

E. Have been diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a substance use disorder, or otherwise have significant BH needs;

F. Are chronically homeless;

G. Are at high risk of inpatient admission or Emergency Department visits, including certain Attributed Members transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting; or

H. Receive care from other state agency programs, including but not limited to programs through Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Children and Families (DCF), and Department of Youth Services (DYS).

BH – Behavioral Health. See Behavioral Health Services.

BH CP - Behavioral Health Community Partner.

Behavioral Health Director – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Behavioral Health Services (or BH Services) – mental health and substance use disorder services that are TCOC Included Services and are set forth in detail in **Appendix A**.

Blue Cross Blue Shield's Alternative Quality Contract – Blue Cross Blue Shield of Massachusetts' global payment model.

Budgets and Budget Narratives – information provided by the Contractor about the Contractor's planned spending of DSRIP payments, as described in **Section 4.1.B**.

Business Associate – a person, organization or entity meeting the definition of a "business associate" for purposes of the Privacy and Security Rules (45 CFR §160.103)**.**

Care Coordinator – a provider-based clinician or other trained individual who is employed or contracted by the Contractor or an Attributed Member's PCP. The Care Coordinator is accountable for providing care coordination activities, which include ensuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the PCP; participating in the Attributed Member's Comprehensive Assessment, if any; and supporting safe transitions in care for Attributed Members moving between settings in accordance with the Contractor's Transitional Care Management program. The Care Coordinator may serve on one or more care teams, and coordinates and facilitates meetings and other activities of those care teams.

Care Management – the provision of person-centered, coordinated activities to support Attributed Members' goals as described in **Section 2.5.E**.

Care Needs Screening – a screening to identify an Attributed Member's care needs and other characteristics as described in **Section 2.5.B**.

Care Plan – the plan of care developed by the Attributed Member and other individuals involved in the Attributed Member's care or Care Management, as described in Section **2.5.D.2**.

Care Team Point of Contact – A member of a BH CP-Engaged Attributed Member's Care Team responsible for ongoing communication with the Care Team. The Care Team Point of Contact may be the Enrollee's PCP or PCP Designee, or the Contractor's staff member that has face-to-face contact with the PCP or the Care Team.

Chief Financial Officer – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Chief Medical Officer/Medical Director – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Child and Adolescent Needs and Strengths (CANS) Tool – a tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Mental Health Services and Community Based Acute Treatment Services as described in **Appendix A**. A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health providers serving Attributed Members under the age of 21.

Children's Behavioral Health Initiative (CBHI) -- an interagency undertaking by EOHHS and MassHealth whose mission is to strengthen, expand and integrate Behavioral Health Services for Members under the age of 21 into a comprehensive system of community-based, culturally competent care.

Children's Behavioral Health Initiative Services (CBHI Services) – any of the following services: Intensive Care Coordination (ICC), Family Support and Training, In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services, In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support), and Mobile Crisis Intervention.

Clinical Advice and Support Line – a phone line that provides Attributed Members with information to support access to and coordination of appropriate care, as described in **Section 2.5.C.3**.

Clinical Care Manager – a licensed Registered Nurse or other individual, employed by the Contractor or an Attributed Member's PCP and licensed to provide clinical care management, including intensive monitoring, follow-up, and care coordination, and clinical management of high-risk Attributed Members, as further specified by EOHHS.

Clinical Quality Measures – clinical information from Attributed Members' medical records used to determine the overall quality of care received by Attributed Members or Members. Clinical Quality Measures are a subset of Quality Measures and are set forth in **Appendix B**.

Cold-call Marketing – any unsolicited personal contact by the Contractor, its employees, providers, agents or Material Subcontractors with a Member who is not attributed to the Contractor's plan that EOHHS can reasonably interpret as influencing the Member to enroll in or either not to enroll in, or to disenroll from, another MassHealth-contracted ACO, MassHealth-contracted Managed Care Organization, or the PCC Plan. Cold-call Marketing shall not include any personal contact between a provider and a Member who is a prospective, current or former patient of that provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular member.

Community Partners (CPs) – entities procured by EOHHS to work with ACOs and MCOs to ensure integration of care, as further specified by EOHHS. Includes BH CPs and LTSS CPs.

Community Partner Assigned Attributed Member – an Attributed Member who is assigned to a BH or LTSS CP (BH CP-Assigned Attributed Member and LTSS CP-Assigned Attributed Member, respectively).

Community Partner Documented Processes - written documents approved by all parties to the ACO/MCO-CP Agreement that outline the steps necessary to complete a task or function, as described in **Appendices G** and **H**.

Community Partner Engaged Attributed Member –

- **BH CP-Engaged Attributed Member** – a BH CP-Assigned Attributed Member for whom the BH CP has completed a Comprehensive Health Assessment and Member-centered treatment plan, and the Member-centered treatment plan has been signed or otherwise approved by the BH CP-Assigned Attributed Member (or legal authorized representative, as appropriate) and approved and signed by the BH CP-Assigned Attributed Member's PCP or PCP Designee.

- **LTSS CP-Engaged Attributed Member** – an LTSS CP-Assigned Attributed Member for whom the LTSS CP has completed the LTSS component of the LTSS CP-Assigned Attributed Member's Care Plan, and the LTSS component of the LTSS CP-Assigned Attributed Member's Care Plan has been signed or otherwise approved by the Attributed Member (or legal authorized representative, as appropriate) and approved and signed by the LTSS CP-Assigned Attributed Member's PCP or PCP Designee.

Community Partner Identified Attributed Member – an Attributed Member who is identified by EOHHS for assignment to a BH or LTSS CP based on MassHealth claims (BH CP-Identified Attributed Member and LTSS CP-Identified Attributed Member, respectively).

Community Partners Operational Start Date -- the date on which CPs start to provide CP supports as determined by EOHHS. The Community Partners Operational Start Date is anticipated to be June 1, 2018.

Community Partner Referred Attributed Member – an Attributed Member who is recommended for assignment to a BH or LTSS CP by the Attributed Member, a PCP, providers, or others as further specified by EOHHS (BH CP-Referred Attributed Member and LTSS CP-Referred Attributed Member, respectively).

Community Service Agency (CSA) – a community-based Behavioral Health provider organization whose function is to facilitate access to the continuum of Behavioral Health services by providing an organized pathway to care for children and families where the child is referred for Intensive Care Coordination. A primary mechanism through which CSAs serve this function is as the provider of Intensive Care Coordination and Family Support and Training Services, which are defined as a BH Service.

Comprehensive Assessment – a person-centered assessment of an Attributed Member's care needs, functional needs, accessibility needs, goals, and other characteristics, as described in **Section 2.5.D.1.l.**

Contract – this agreement executed between EOHHS and the Contractor pursuant to the RFR and any amendments thereto. The Contract incorporates by reference all attachments and appendices thereto, including the Contractor's response to the RFR.

Contract Effective Date - the date on which the Contract is effective, which shall be the date this Contract is fully executed by both parties.

Contract Year (CY) – for Contract Year 1, a ten-month period commencing March 1, 2018 and ending December 31, 2018, unless otherwise specified by EOHHS. For other Contract Years, a twelve-month period commencing January 1 and ending December 31, unless otherwise specified by EOHHS.

Contracting MCO – a MassHealth-contracted MCO with which the Contractor has an Approved ACO Agreement.

Contractor (or "MCO-Administered Accountable Care Organization," or "MCO-Administered ACO) – any entity that executes this Contract with EOHHS for the performance of the responsibilities described herein.

Covered Entity – shall have the meaning given to this term in the Privacy and Security Rules.

Cultural and Linguistic Competence – competence, understanding, and awareness with respect to Culturally and Linguistically Appropriate Services.

Culturally and Linguistically Appropriate Services – health care services that are respectful of and responsive to cultural and linguistic needs, and that are characterized by cultural and linguistic competence, as described in the Culturally and Linguistically Appropriate Services (CLAS) standards set forth by the Office of Minority Health of the U.S. Department of Health and Human Services. More detail on CLAS standards may be found here: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf.

Customer Service Center (CSC) Enrollment Vendor – EOHHS's enrollment broker that provides Members with a single point of access to a wide range of customer services, including enrolling Members into MCOs and the PCC Plan, authorizing non-emergency transportation services, and providing Members with information about non-ACO covered services.

Delivery System Reform Incentive Payment (DSRIP) – a funding program under MassHealth's 1115 Demonstration Waiver through which EOHHS is providing payments to ACOs and other entities to support EOHHS' delivery system reform goals.

Delivery System Transformation Initiatives (DSTI) – Massachusetts initiative that provides incentive payments to eligible hospitals for delivery system transformation activities as approved under MassHealth's section 1115 Demonstration waiver.

Disability Coordinator – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Disease Management – the Contractor's ongoing services and assistance for specific disease and/or conditions. Services include specific interventions, education, and outreach targeted to Attributed Members with, or at risk for, these diseases or conditions.

DSRIP Accountability Score – a composite score calculated by EOHHS to evaluate the Contractor's performance under this Contract and determine DSRIP payment amounts, as described in **Appendix B.**

DSRIP Participation Plan – information provided by an ACO related to the ACO's DSRIP investments and activities under the Contract, as described in **Section 4.1.A**.

DSRIP Performance Year ("Performance Year") – an administrative period related to DSRIP and related purposes. For Performance Year 0, a six-month period commencing on the Contract Effective Date and ending December 31, 2017, unless otherwise specified by EOHHS. For other Performance Years, a twelve-month period commencing January 1 and ending December 31, unless otherwise specified by EOHHS.

DSRIP Program's State Accountability Protocols – the terms of financial accountability under Massachusetts' DSRIP agreement with the federal government, determining the percent of Massachusetts' DSRIP spending authority that is at risk based on state performance.

DSTI Glide Path Payments – DSRIP payments made to certain ACOs to support the transition of Participating Safety Net Hospitals.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - the delivery of health care services to MassHealth Standard and CommonHealth Members under the age of 21, pursuant to 42 USC 1396d(a)(4), 42 CFR Part 441, Subpart B, 130 CMR 450.140-149 and § 1115 Medicaid Research and Demonstration Waiver.

Effective Date of Disenrollment - up to 11:59 p.m. on the last day, as determined by EOHHS, on which the Contractor is responsible for providing the activities described in this Contract to an Attributed Member, as further defined by EOHHS.

Effective Date of Enrollment – as of 12:01 a.m. on the first day on which the Contractor is responsible for providing the activities described in this Contract to an Attributed Member and as reflected in the HIPAA 834 Outbound Enrollment File.

Emergency Services Programs (ESPs) – Medically necessary services provided through designated, contracted providers, and which are available seven (7) days per week, twenty-four (24) hours per day to provide treatment of any individual who is experiencing a mental health or substance use disorder crisis, or both. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization, as described in **Appendix C**.

Event Notification Service (ENS) – a HIway-sponsored service that provides real-time alerts about certain patient medical service encounters, for example, at the time of hospitalization, to a permitted recipient with an existing treatment relationship to the patient, such as a primary care provider.

Executive Office of Health and Human Services (EOHHS) – The single state agency 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 Section 1115 Medicaid Research and Demonstration Waiver, and other applicable laws and waivers.

External Quality Review Activities (EQR Activities) - activities performed by an entity with which EOHHS contracts in accordance with 42 CFR 438.358.

External Quality Review Organization (EQRO) – the entity with which EOHHS contracts to perform External Quality Review Activities (EQR Activities), in accordance with 42 CFR 438.358.

Flexible Services – certain services to address health-related social needs, for which expenditures are allowable for DSRIP reimbursement as described in **Section 4.2.C**.

Flexible Services DSRIP Allotment – an amount of DSRIP funding available to the Contractor for reimbursement for qualifying expenses on Flexible Services, as described in **Section 4.2.C**.

Governing Board – a board or other legal entity with sole and exclusive authority to execute the functions in this Contract, make final decisions on behalf of Contractor, and the members of which have a fiduciary duty to Contractor.

Grievance – any expression of dissatisfaction by an Attributed Member or an Attributed Member's representative 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 the Contractor, or failure to respect the Attributed Member's rights.

Health Information Technology (HIT) – The application of information processing involving both computer hardware and software related to the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision-making.

Hepatitis C Virus Drugs (HCV Drugs) – Direct acting-antiviral (DAA) single and combination drugs, as further specified by EOHHS.

Historic TCOC – an amount calculated by EOHHS based on the Contractor's historic baseline for TCOC as described in **Section 2.7.D.2.c**

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**.**

Key Contact – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Key Personnel – a defined subset of the Contractor's staff roles as described in **Section 2.3.A**.

Long-Term Services and Supports (LTSS) – a wide variety of services and supports that help certain members meet their daily needs for assistance and improve the quality of their lives. Examples include 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.

LTSS CPs – Long-Term Services and Supports Community Partners.

Losses – the amount by which the Contractor's TCOC Performance exceeds the Contractor's TCOC Benchmark as described in **Section 2.7.A**.

Managed Care Organization (MCO) – any entity that provides, or arranges for the provision of, covered services under a capitated payment arrangement, that is licensed and accredited by the Massachusetts Division of Insurance as a Health Maintenance Organization (HMO), and is organized primarily for the purpose of providing health care services, that (a) meets advance directives requirements of 42 CFR Part 489, subpart I; (b) makes the services it provides to its enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Members within the area served by the entity; (c) meets the EOHHS's solvency standards; (d) assures that its enrollees will not be liable for the MCO's debts if the MCO becomes insolvent; (e) is located in the United States; (f) is independent from EOHHS' enrollment broker, as identified by EOHHS; and (g) is not an excluded entity described in 42 CFR 438.808(b).

Market-Rate TCOC – an amount calculated by EOHHS based on the Contractor's anticipated TCOC based on the total eligible population as described in **Section 2.7.D.2.d**.

Marketing – any communication from the Contractor, its employees, providers, agents or Material Subcontractors to a Member who is not enrolled with the Contractor that EOHHS can reasonably interpret as influencing the Member to enroll with the Contractor or either not to enroll in, or to disenroll from, another MassHealth-contracted ACO, MCO, or the PCC Plan. Marketing shall not include any personal contact between a provider and a Member who is a prospective, current or former patient of that provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Member.

Marketing Materials – materials that are produced in any medium, by or on behalf of the Contractor and that EOHHS can reasonably interpret as Marketing to Members. This includes the production and dissemination by or on behalf of the Contractor of any promotional material or activities by any medium including, but not limited to, oral presentations and statements, community events, print media, audio visual tapes, radio, television, billboards, online, Yellow Pages, and advertisements that explicitly or implicitly refer to MassHealth Managed Care or Title XIX and Title XXI of the Social Security Act, and are targeted in any way toward Members.

Massachusetts Health Information Highway (**Mass HIway) —** Massachusetts' statewide electronic health information exchange.

MassHealth – The medical assistance or benefit programs administered by EOHHS.

MassHealth ACO Program – collectively, MassHealth's Accountable Care Partnership Plans, MassHealth's Primary Care ACOs, and MassHealth's MCO-Administered ACOs.

MassHealth Executive Director – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Material Subcontractor - any entity from which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of its responsibilities under this Contract for Care Management, data analysis, member services and/or risk stratification, as further directed by EOHSS, and any other Contract responsibilities as specified by EOHHS.

Medicaid – see MassHealth.

Medically Necessary – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Attributed Member 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 (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Attributed Member 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.

Medicare ACO – accountable care contracts administered by the Medicare program, including the Medicare Shared Savings Program, the Pioneer ACO program, and the CMS Next Generation ACO program.

Medication for Addiction Treatment (MAT) Services - The use of FDA approved medications for the treatment of substance use disorders.

Member – a person determined by EOHHS to be eligible for MassHealth.

Mobile Crisis Intervention (MCI) – services provided by the ESPs listed in **Appendix C** to individuals under age 21. MCI services include a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.

Non-HCV High Cost Drugs – drugs included in **Appendix E**.

Ombudsman – a neutral entity that has been contracted by MassHealth to assist Attributed Members (including their families, caregivers, representatives and/or advocates) with information, issues, or concerns.

Operational Start Date - the date on which the Contractor starts to provide the activities described in this Contract to Attributed Members. This date is at the discretion of EOHHS, but is anticipated to be March 1, 2018.

Participating PCP – a PCP that contracts with the Contractor for the purposes of this Contract as described in **Section 2.2.A**.

Participating Safety Net Hospital – a Safety Net Hospital that affiliates with the Contractor for the purposes of this Contract as described in **Section 2.2.C**.

Patient and Family Advisory Committee – a committee that gathers the perspectives of patients and families on the Contractor's operations and regularly informs the Contractor's Governing Board.

Patient Experience Survey – a survey of Attributed Members' experiences of care, performed to evaluate the Contractor's performance, as described in **Appendix B**.

PCP Designee – a licensed clinician appointed by an Attributed Member's PCP to participate in the Attributed Member's care planning process and who has face-to-face contact with the Attributed Member's PCP and serves on the Attributed Member's Care Team. The PCP Designee must be a Registered Nurse (RN) or another licensed medical professional such as a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), or Physician's Assistant (PA). The PCP Designee may also be a specialist, such as an Attributed Member's cardiologist or neurologist, if requested by the Attributed Member and agreed to by the Attributed Member's PCP.

Peer Supports – activities to support recovery and rehabilitation provided by other consumers of behavioral health services.

Prevalent Languages – those languages spoken by a significant percentage of Attributed Members. EOHHS has determined the current Prevalent Languages spoken by MassHealth Attributed Members are Spanish and English. EOHHS may identify additional or different languages as Prevalent Languages at any time during the term of the Contract.

Primary Care – the provision of coordinated, comprehensive medical services, on both a first contact and a continuous basis, to an Attributed Member. 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 Clinician (PCC) Plan – a managed care option administered by EOHHS through which enrolled MassHealth Members receive Primary Care and certain other medical services. See 130 CMR 450.118.

Primary Care Provider (PCP) – the individual Primary Care Provider or team selected by the Attributed Member, or assigned to the Attributed Member by the Contractor, to provide and coordinate all of the Attributed Member's health care needs and to initiate and monitor referrals for specialty services when required. PCPs include nurse practitioners practicing in collaboration with a physician under Massachusetts General Laws Chapter 112, Section 80B and its implementing regulations or physicians who are board certified or eligible for certification in one of the following specialties: Family Practice, Internal Medicine, General Practice, Adolescent and Pediatric Medicine, or Obstetrics/Gynecology (for women only). PCPs for persons with disabilities, including but not limited to, persons with HIV/AIDS, may include practitioners who are board certified or eligible for certification in other relevant specialties.

Privacy and Security Rules – the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR Parts 160 and 164).

Progress Reports – information provided by the Contractor on the Contractor's activities under this Contract, as described in **Section 4.1.C**.

Protected Information (PI) - any "protected health information" (PHI) as used in the Privacy and Security Rules, any "personal data" as defined in M.G.L. c. 66A, any "patient identifying information" as used in 42 CFR Part 2, any "personally identifiable information" as used in 45 CFR §155.260 and/or any other individually identifiable information that is treated as confidential under applicable privacy or security law or regulation that the Contractor (or its subcontractor or agent) creates, receives, acquires, uses, transmits or maintains in connection with its provision of CP Supports and/or its performance of a function or activity for or on behalf of EOHHS under the Contract or an ACO or MCO under a ACO/MCO and CP Agreement. Information, including aggregate information, is considered PI if it is not fully de-identified in accord with 45 CFR §§164.514(a)-(c).

Quality Committee – a committee reporting directly to the Contractor's Governing Board, which regularly reviews and sets goals to improve the Contractor's performance on clinical quality or health outcomes, Attributed Member experience measures, other Quality Measures, and disparities.

Quality Measures – Measures used to evaluate the quality of the Contractor's Attributed Members' care as described in **Appendix B.**

Quality Sample – a subset of Members defined by EOHHS used for measurement of Clinical Quality Measures as set forth in **Appendix B.**

Quality Score – a score calculated by EOHHS based on the Contractor's performance on Quality Measures, as described in **Appendix B**.

Rating Category (RC) – An identifier used by EOHHS to identify a specific grouping of Enrollees for which a discrete TCOC applies pursuant to the Contract. Rating Categories include RC I Adult, RC I Child, RC II Adult, RC II Child, RC IX, and RC X. RC II Adult, as used in Section 2.7, includes Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

Region – A geographic area used for the purpose of the development of TCOC. See **Section 2.7.**

Risk Track – one of the financial accountability arrangements described in **Section 2.7.B**.

Safety Net Hospitals – Boston Medical Center; Cambridge Health Alliance; Holyoke Medical Center; Lawrence General Hospital; Mercy Medical Center; Signature Healthcare Brockton Hospital; and Steward Carney Hospital.

Savings – the amount by which the Contractor's TCOC Benchmark exceeds the Contractor's TCOC Performance as described in **Section 2.7.A**.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) – an evidence-based approach to addressing substance use in health care settings.

Serious Emotional Disturbance (SED) – a Behavioral Health condition that meets the definition set forth in the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations or the definition set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services, 58 Fed. Reg. 29422-02 (May 10, 1993), as currently drafted and subsequently amended.

Severe and Persistent Mental Illness (SPMI) – a mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and is the primary cause of functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified with the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders, including delirium, dementia or amnesia; or (c) mental disorders due to general medical condition not elsewhere classified; or (d) substance-related disorders.

Shared Losses – the amount to be paid by the Contractor to the Contracting MCO under the Contractor's Risk Track, in the event the Contractor has Losses, as described in **Section 2.7**.

Shared Savings – the amount to be paid by the Contracting MCO to the Contractor under the Contractor's Risk Track, in the event the Contractor has Savings, as described in **Section 2.7**.

Significant BH Needs – substance use disorder, SED, SPMI and other BH conditions as specified by EOHHS.

Startup and Ongoing Support Payments – DSRIP payments that support the Contractor's development, infrastructure, and investments in new care delivery models, as described in **Section 4.2.A**.

State Agency Liaison – one of the Contractor's Key Personnel roles, as described in **Section 2.3.A**.

Taxpayer Identification Number –As defined by the Internal Revenue Service (IRS), an identification number issued by the IRS or by the Social Security Administration (SSA). A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS.

Total Cost of Care (TCOC) – a measure of the costs of care for a population of Attributed Members during a defined period, as described in **Section 2.7.E.1**.

TCOC Benchmark – a target measure of the Contractor's TCOC for the Contract Year, as described in **Section 2.7.E.2**.

TCOC Included Services – the services that are included in calculating the Contractor's TCOC, as set forth in **Appendix A**.

TCOC Performance – a measure of the Contractor's performance on TCOC during the Contract Year, as described in **Section 2.7.D.3**.

Transitional Care Management – the evaluation of an Attributed Member'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, as described in **Section 2.5.C.2.**

Urgent Care – services that are not Emergency Services or routine services.

Wellness Initiatives – planned health education activities intended to promote healthy behaviors and lifestyle changes.

CONTRACTOR RESPONSIBILITIES

CONTRACTOR QUALIFICATIONS

As further specified by EOHHS, the Contractor shall meet, and demonstrate to EOHHS that it meets, the following qualifications.

GOVERNANCE STRUCTURE

At all times during the Contract Term, the Contractor shall have a governance structure that includes:

A GOVERNING BOARD. SUCH GOVERNING BOARD SHALL:

BE SEVENTY-FIVE PERCENT CONTROLLED BY PROVIDERS OR THEIR DESIGNATED REPRESENTATIVES; AND

INCLUDE AT LEAST ONE CONSUMER OR CONSUMER ADVOCATE AS A VOTING MEMBER. SUCH CONSUMER OR CONSUMER ADVOCATE SHALL NOT BE INCLUDED IN EITHER THE NUMERATOR OR THE DENOMINATOR IN CALCULATING THE SEVENTY-FIVE PERCENT CONTROL THRESHOLD REQUIREMENT OF **SECTION 2.1.A.1.A**;

REPRESENTATION FROM A VARIETY OF PROVIDER TYPES, INCLUDING AT A MINIMUM REPRESENTATION FROM PRIMARY CARE, MENTAL HEALTH, AND SUBSTANCE USE DISORDER TREATMENT PROVIDERS;

A PATIENT AND FAMILY ADVISORY COMMITTEE; AND

A QUALITY COMMITTEE.

CERTIFICATIONS AND CONFLICT OF INTEREST

THE CONTRACTOR SHALL ACQUIRE AND MAINTAIN HEALTH POLICY COMMISSION (HPC) ACO CERTIFICATION AS FOLLOWS:

IF EOHHS DETERMINES THAT THE CONTRACTOR HAS PARTICIPATED IN A MEDICARE ACO, THE BCBS ALTERNATIVE QUALITY CONTRACT, OR THE MASSHEALTH ACO PILOT PROGRAM, THE CONTRACTOR SHALL APPLY FOR AND ACQUIRE NON-PROVISIONAL ACO CERTIFICATION FROM THE HPC BY JANUARY 1, 2018; OR

IF EOHHS DETERMINES THAT THE CONTRACTOR HAS NOT PARTICIPATED IN A MEDICARE ACO, THE BCBS ALTERNATIVE QUALITY CONTRACT, OR THE MASSHEALTH ACO PILOT PROGRAM, THE CONTRACTOR SHALL:
APPLY FOR AND ACQUIRE PROVISIONAL ACO CERTIFICATION FROM THE HPC BY JANUARY 1, 2018; AND
APPLY FOR AND ACQUIRE NON-PROVISIONAL ACO CERTIFICATION FROM THE HPC WITHIN ONE YEAR OF THE OPERATIONAL START DATE; AND

The Contractor shall obtain and, at all times after the Operational Start Date, maintain a Risk Certificate for Risk-Bearing Provider Organizations (RBPO) or a Risk Certificate Waiver for RBPO, as defined by the Massachusetts Division of Insurance (DOI), and as further directed by EOHHS; and

At all times after the Operational Start Date, the Contractor shall use best efforts to have a minimum of approximately five thousand (5,000) total Attributed Members across all the Contractor's Approved ACO Agreements, unless with prior written approval from EOHHS;

At all times during the Contract Term, the Contractor shall:

Be located within the United States;

Not have, nor may any of the Contractor's Material Subcontractors have, any financial, legal, contractual or other business interest in EOHHS's enrollment broker, or in such vendor's subcontractors, if any;

Not have, nor may any of the Contractor's Material Subcontractors have, any financial, legal, contractual or other business interest in EOHHS's External Quality Review Organization contractor, or in such vendor's subcontractors, if any.

Relationships with Affiliated Providers

The Contractor shall establish and maintain relationships with Affiliated Providers as follows:

Participating PCPs

The Contractor shall contract with one or more PCPs to serve as Participating PCPs. The Contractor shall:

Ensure that the Contractor's contract with each Participating PCP:
Requires the Participating PCP to:
Share clinical data on Attributed Members with the Contractor as required to support the Quality Measure reporting requirements described in Section 2.3.B.1, subject to all applicable laws and regulations;
Observe and comply with the member rights and protections described in Section 2.6;
Provide care to Attributed Members in accordance with the care model requirements described in Section 2.5; and
Otherwise assist the Contractor with meeting the requirements of this Contract, including documenting information in an Attributed Member's medical record;

Requires that the Participating PCP shall not contract as a:

Participating PCP with any entity, except the Contractor, that is participating as part of the MassHealth ACO Program;
PCP for an entity serving as a MassHealth-contracted MCO that does not have an Approved ACO Agreement with the Contractor, except when such PCP is serving a Special Kids Special Care (SKSC) Program Attributed Member; or
Primary Care Clinician within MassHealth's PCC Plan;

Has a term of a minimum of one year from the Operational Start Date; and

May only be terminated for cause;

Develop, implement, and maintain value-based payments for Participating PCPs. Such value-based payments may by for individual Participating PCPs or for practices, pods, or other groupings of Participating PCPs. Such value-based payments shall:

Be subject to prior approval by EOHHS;

Be made in accordance with any guidance or requirements issued by EOHHS, including requiring specific payment arrangements;

Not replace payment Participating PCPs receive for providing covered services to Attributed Members or Members, including payment Participating PCPs receive from MassHealth-contracted MCOs;

Shift financial incentives away from volume-based, fee-for-service delivery for Participating PCPs by:
Holding each Participating PCP or group of PCPs financially accountable to some degree for the Contractor's performance under the Contractor's Approved ACO Agreements and for the Participating PCP's or group's contribution to that performance, with potential for the Participating PCP or group to share gains from savings or share payment responsibility for losses, such that PCPs or groups of PCPs experience a meaningful portion of their annual Medicaid patient service revenue opportunity being tied to value-based performance measures;
Making the value-based payments based on a performance measurement and management process as described in **Section 2.2.A.2.e**; and
Reducing the influence of volume-based, fee-for-service incentives on Participating PCPs;

Include performance measurement and management activities such as but not limited to:
Regularly evaluating each Participating PCP's performance on TCOC, Quality Measures, or related measures of performance under the Contractor's Approved ACO Agreements, and performing practice pattern variation analysis to identify opportunities for individual Participating PCPs to improve performance on these measures;
Transparently reporting to each Participating PCP on the performance of the Participating PCP on such measures;
Identifying Participating PCPs with unsatisfactory performance or opportunities to improve performance on the Contractor's identified measures, and implementing plans to improve such performance; and

Adjusting value-based payments based on Participating PCPs' performance to provide financial incentives for improved performance;

Be accomplished through payment arrangements approved by EOHHS. Such payment arrangements may include:
Guaranteeing a set amount of revenue to Participating PCPs each month for the anticipated costs of Primary Care, and reconciling this amount against Participating PCPs' actual billing revenue each month, providing supplemental payments as needed. Such an arrangement may be expanded to include BH services, if a Participating PCP is also a provider of such services. Such payments may also include adjustments for performance;
Stand-alone performance incentives or prize pools for Participating PCPs based on performance on process or outcomes measures identified by the Contractor that are related to costs of care, Contractor's Quality Measures, and utilization;
Additional payments (e.g., supplemental medical home loads) paid to Participating PCPs that augment rates paid by MassHealth-contracted MCOs, to support new costs associated with the Participating PCPs' responsibilities. Such payments shall include adjustments for performance; and
Partial distribution of the Contractor's Shared Savings payments or responsibility for contributing to the Contractor's Shared Losses payments to Participating PCPs based on performance;

Spend an amount of the Contractor's Startup and Ongoing DSRIP funding on investments in Participating PCPs, as described in **Section 4.1.F.3**. In addition to the other requirements of this Contract, such investments shall comply with the requirements of Section 4.1, including requirements for proposing such activities and receiving EOHHS approval through Contractor's DSRIP Participation Plan. The Contractor's investments in its Participating PCPs shall:

Increase the capabilities of Participating PCPs to share information with the Contractor and with other providers to coordinate care for Attributed Members;

Increase the capabilities of Participating PCPs to perform and participate in the Contractor's Care Management activities, including providing additional supports to Attributed Members;

Include but not be limited to investments such as:
Investment in primary care technological infrastructure, including:
HIT infrastructure deployed in the Primary Care setting;
Clinical platforms for Primary Care Providers;
Fixed cost investments to support telehealth and costs for related non-reimbursable activities;
Data sharing across Primary Care and Behavioral Health providers to support Behavioral Health integration in Primary Care practices; and
Data analytics and informatics to support individual Primary Care practices;
Investment in Primary Care workforce to support the Contractor's activities under this Contract and the Contractor's Approved ACO Agreements, including hiring practice extenders and other personnel, such as

COMMUNITY HEALTH WORKERS, LICENSED SOCIAL WORKERS, PROVIDERS OF BH OR PRIMARY CARE SERVICES, OR OTHER OFFICE PERSONNEL TO WORK IN PRIMARY CARE SETTINGS WITHIN THEIR SCOPE OF PRACTICE UNDER STATE LAW; AND TRAINING AND TECHNICAL ASSISTANCE THAT DIRECTLY SUPPORTS PARTICIPATING PCPS TO IMPROVE PERFORMANCE AND INCREASE PARTICIPATION IN CONTRACTOR'S ACTIVITIES UNDER THIS CONTRACT AND THE CONTRACTOR'S APPROVED ACO AGREEMENTS, INCLUDING ASSISTANCE WITH ANALYTICS, EXECUTING PLANS FOR PERFORMANCE IMPROVEMENT, QUALITY MEASUREMENT AND MANAGEMENT, AND CARE COORDINATION AND CARE MANAGEMENT ACTIVITIES SUCH AS THOSE DESCRIBED IN **SECTION 2.5**; AND

Participating PCP Modifications

THE CONTRACTOR MAY REQUEST EOHHS' APPROVAL ANNUALLY FOR ADDITIONS TO THE CONTRACTOR'S LIST OF PARTICIPATING PCPS THROUGH THE ACCOUNTABLE CARE ORGANIZATION PRIMARY CARE PROVIDER ADDITIONS PROCESS, AS FURTHER SPECIFIED BY EOHHS. IF A REQUESTED ADDITION IS APPROVED, THE NEW PCP WILL BE ADDED TO THE CONTRACTOR'S LIST OF PARTICIPATING PCPS FOR AN EFFECTIVE DATE TO BE FURTHER SPECIFIED BY EOHHS; AND

THE CONTRACTOR SHALL REQUEST PROVIDER FILE MAINTENANCE FOR CERTAIN PARTICIPATING PCP MODIFICATIONS ON AN ONGOING BASIS AS FURTHER SPECIFIED BY EOHHS.

EOHHS SHALL PROVIDE THE CONTRACTOR WITH SPECIFICATIONS ABOUT THE ACCOUNTABLE CARE ORGANIZATION PRIMARY CARE PROVIDER ADDITIONS PROCESS AND PROVIDER FILE MAINTENANCE PROCESS. SUCH SPECIFICATIONS MAY INCLUDE WHEN THE CONTRACTOR MUST USE EACH PROCESS DEPENDING ON A NUMBER OF FACTORS, INCLUDING BUT NOT LIMITED TO ANY ASSOCIATION BETWEEN A PROPOSED PCP'S TIN AND EITHER THE CONTRACTOR'S TIN OR AN EXISTING PCP'S TIN.

AFFILIATED HOSPITALS

THE CONTRACTOR SHALL HAVE AGREEMENTS WITH AT LEAST ONE HOSPITAL TO SUPPORT CONTRACTOR'S ACTIVITIES UNDER THIS CONTRACT AND THE CONTRACTOR'S APPROVED ACO AGREEMENTS AND AS FURTHER SPECIFIED BY EOHHS. SUCH HOSPITAL(S) SHALL BE AFFILIATED HOSPITAL(S);

THE CONTRACTOR SHALL DEVELOP, IMPLEMENT, AND MAINTAIN PROTOCOLS WITH EACH AFFILIATED HOSPITAL THAT SUPPORT THE COORDINATION OF ATTRIBUTED MEMBERS' CARE, AS PART OF THE CONTRACTOR'S TRANSITIONAL CARE MANAGEMENT PROGRAM AS DESCRIBED IN **SECTION 2.5.C.2**. SUCH PROTOCOLS SHALL BE IN ACCORDANCE WITH CONTRACTOR'S EOHHS-APPROVED DSRIP PARTICIPATION PLAN AS DESCRIBED IN **SECTION 4.1.A**.

PARTICIPATING SAFETY NET HOSPITALS

The Contractor may include as Affiliated Hospitals one or more Safety Net Hospitals, as identified by EOHHS, and may designate such Safety Net Hospitals to serve as the Contractor's Participating Safety Net Hospital. Participating Safety Net Hospitals shall be considered Affiliated Hospitals for purposes of the requirements of **Section 2.2.B**. The Contractor shall:

ENSURE THAT EACH AFFILIATED HOSPITAL ARRANGEMENT WITH A PARTICIPATING SAFETY NET HOSPITAL:

Is approved by EOHHS;

Has a term of a minimum of one year from the Operational Start Date;

May only be terminated for cause; and

Requires that the Participating Safety Net Hospital shall not contract as a Participating Safety Net Hospital with any entity, except the Contractor, that is participating as part of the MassHealth ACO Program; and

Requires that the Participating Safety Net Hospital share meaningfully in the Contractor's financial accountability for performance under the Contract, as follows and as further specified by EOHHS:
Such financial accountability shall include one or more of the following arrangements:
Financial and performance accountability for the cost and quality of episodes of care (e.g. bundled payments);
A Total Cost of Care (TCOC) sub-budget with accountability for quality;
Other performance accountability including financial penalties and bonuses; or
An arrangement under which the Participating Safety Net Hospital otherwise financially participates in the savings and losses of the Contractor, such as through the Participating Safety Net Hospitals' corporate affiliation to or common ownership with the Contractor;
As determined by EOHHS, the Participating Safety Net Hospital shall bear more than nominal risk in the financial accountability arrangement, such that the cumulative maximum annual potential for losses or gains based on the Participating Safety Net Hospital's performance is not less than one of the following
25% of the annual value of the Participating Safety Net Hospital's DSTI Glide Path payment;
1% of the Participating Safety Net Hospital's total Medicaid patient service revenue; or
If applicable, 30% of the difference between the Participating Safety Net Hospital's TCOC sub-budget benchmark and actual TCOC sub-budget performance;

The Contractor shall obtain EOHHS approval for its arrangement with the Participating Safety Net Hospital, including providing documentation of the financial participation agreement(s) internal to the Participating Safety Net Hospital's corporate affiliation, as further specified by EOHHS;

Pay each Participating Safety Net Hospital the full amount of DSTI Glide Path Payments Contractor receives for such Participating Safety Net Hospital, as described in **Section 4.2.B**;

Ensure that the written arrangement with the Participating Safety Net Hospital satisfied all applicable Contract requirements related to Affiliated Providers;

Nothing in this **Section 2.2.D** prohibits a Participating Safety Net Hospital from contracting with another MassHealth ACO, MCO, or the PCC Plan as a Network Hospital.
Other Affiliated Providers

THE CONTRACTOR MAY ESTABLISH AGREEMENTS WITH OTHER AFFILIATED PROVIDERS TO SUPPORT CONTRACTOR'S ACTIVITIES UNDER THIS CONTRACT. THE CONTRACTOR SHALL DISCLOSE SUCH AGREEMENTS TO EOHHS; AND

THE CONTRACTOR SHALL REPORT INFORMATION ON SUCH AFFILIATED PROVIDERS AS NECESSARY TO FACILITATE DATA REPORTING, AS FURTHER DIRECTED BY EOHHS.

COMMUNITY PARTNERS

The Contractor shall contract with Behavioral Health Community Partners (BH CPs) and Long-Term Services and Supports Community Partners (LTSS CPs) as described in **Sections 2.8.A and 2.8.B**.

Policies and Procedures

The Contractor shall establish and implement policies and procedures to increase the Contractor's capabilities to share information among providers involved in Attributed Members' care, including:

Increasing connection rates of Affiliated Providers to the Mass HIway;

Adopting and integrating interoperable certified Electronic Health Records (EHR) technologies (such as those certified by the Office of the National Coordinator (ONC);

Enhancing interoperability; and

Increasing the use of real time notification of events in care (such as but not limited to admission of an Attributed Member to an emergency room or other care delivery setting) in accordance with Contractor's DSRIP Participation Plan.

HIPAA Certification

By executing this Contract, the Contractor certifies that:

The Contractor, together with its Participating PCPs, is a Covered Entity; or

The Contractor is a Covered Entity and has entered into an Organized Health Care Arrangement with its Participating PCPs; or

The Contractor is a Business Associate of its Participating PCPs or an Organized Health Care Arrangement to which its Participating PCPs belong for purposes of, at a minimum, performing or providing activities, functions and/or services relating to minimizing the total cost and maximizing the quality of care providing to Attributed Members.

Upon request, the Contractor shall produce documentation supporting its status as a Covered Entity or Business Associate, as set forth above, its relationship with its Participating PCPs, and/or its authority to receive data related to Participating PCPs' Attributed Members for the performance of the Contractor's responsibilities as set forth in this Contract.

Contract Management, Reporting, and Administration

Key Personnel and Other Staff

The Contractor shall have Key Personnel and other staff as set forth in this Section.

The following roles shall be filled by Contractor's Key Personnel:

The Contractor's MassHealth Executive Director, who shall have primary responsibility for the management of this Contract and the Contractor's Approved ACO Agreements and shall be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract;

The Contractor's Chief Medical Officer/Medical Director, who shall be a clinician licensed to practice in Massachusetts and shall oversee Contractor's care delivery responsibilities and Care Management activities as described in **Section 2.5**, and all clinical initiatives including quality improvement activities, including but not limited to clinical initiatives related to addressing the care needs of children;

The Contractor's Behavioral Health Director, who shall be responsible for Contractor's activities related to BH Services and related care delivery responsibilities and Care Management activities as described in **Section 2.5**, and for all BH-related interaction with EOHHS;

The Contractor's Chief Financial Officer, who shall be authorized to sign and certify Contractor's financial documents, as described in this Contract and further specified by EOHHS;

The Contractor's Disability Coordinator, who shall oversee Contractor's and Affiliated Providers' compliance with federal and state laws and regulations pertaining to persons with disabilities, including ensuring that Affiliated Providers provide physical access, communication access, accommodations, and accessible equipment for Attributed Members with physical or mental disabilities;

The Contractor's State Agency Liaison, who shall coordinate Contractor's interaction with state agencies with which Attributed Members may have an affiliation, including but not limited to the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Children and Families (DCF), the Department of Youth Services (DYS), the Department of Public Health (DPH) and the DPH Bureau of Substance Abuse Services (BSAS);

The Contractor's Ombudsman Liaison, who shall liaise with EOHHS' Ombudsman to resolve issues raised by Attributed Members;

The Contractor's Key Contact, who shall liaise with EOHHS and serve as the point of contact for EOHHS for all communications and requests related to this Contract and the Contractor's Approved ACO Agreements; and

Any other positions designated by EOHHS including but not limited to any additional positions related to future policy changes such as the inclusion of LTSS as described in **Section 5.6.C.3**.

The Contractor shall appoint Key Personnel as follows:

The Contractor shall appoint an individual to each of the roles listed in **Section 2.3.A.1**. The Contractor may appoint a single individual to more than one such role;

The Contractor shall have appointments to all Key Personnel roles no later than 90 days prior to the Operational Start Date, and shall notify EOHHS of such initial appointments and provide the resumes of such individuals to EOHHS no later than ten (10) days after such appointments are made;

All individuals assigned to Key Personnel roles shall, for the duration of the Contract, be employed by the Contractor and assigned primarily to perform their job functions related to this Contract;

The Contractor shall, when subsequently hiring, replacing, or appointing individuals to Key Personnel roles, notify EOHHS of such a change and provide the resumes of such individuals to EOHHS no less than ten (10) days after such a change is made;

If EOHHS informs the Contractor that EOHHS is concerned that any Key Personnel are not performing the responsibilities described in this Contract, or are otherwise hindering Contractor's successful performance of the responsibilities of this Contract, the Contractor shall investigate such concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS of such actions. If such actions fail to ensure such compliance to EOHHS' satisfaction, EOHHS may invoke the remedies for poor performance described in **Section 5.22**.

Administrative Staff

The Contractor shall employ sufficient Massachusetts-based, dedicated administrative staff and have sufficient organizational structures in place to comply with all of the requirements set forth herein, including, but not limited to, specifically designated administrative staff dedicated to the Contractor's activities related to:

The Contractor's relationships with CPs and management of the ACO/MCO-CP Agreements;

Risk stratification;

Care Management; and

Population health initiatives and programs.

Other Reporting and Documentation Requirements

In addition to all other reporting and documentation requirements set forth in this Contract, the Contractor shall provide reports and documentation as provided in this Section.

Quality Measure reporting

As further specified by EOHHS, and in a form and format specified by EOHHS, the Contractor shall provide EOHHS with data on the Clinical Quality Measures set forth in **Appendix B** for each Quality Sample as follows:

For each Clinical Quality Measure, the Contractor shall provide EOHHS with complete and accurate medical records data as requested by EOHHS for each Attributed Member in the Quality Sample;

THE CONTRACTOR SHALL PROVIDE ALL REQUESTED CLINICAL DATA IN A FORM AND FORMAT DETERMINED BY EOHHS, NO LATER THAN THIRTY (30) DAYS AFTER RECEIVING SUCH REQUEST. THE CONTRACTOR SHALL PROVIDE SUCH DATA IN AGGREGATE FORM, IF SO REQUESTED BY EOHHS; AND

THE CONTRACTOR SHALL PROVIDE EOHHS WITH ANY ADDITIONAL DATA OR INFORMATION AS REQUESTED BY EOHHS TO AUDIT OR VALIDATE THE QUALITY DATA THE CONTACTOR PROVIDES IN ACCORDANCE WITH THIS SECTION;

DOCUMENTATION

Upon EOHHS' request, the Contractor shall submit any and all documentation and materials pertaining to its performance under this Contract in a form and format designated by EOHHS. Such documentation shall include, but shall not be limited to the Contractor's:

APPROVED ACO AGREEMENTS;

LIST OF PARTICIPATING PCPS, AND DOCUMENTATION DEMONSTRATING CONTRACTOR'S COMPLIANCE WITH THE REQUIREMENTS OF **SECTION 2.2.A**, INCLUDING BUT NOT LIMITED TO MODEL AND EXECUTED CONTRACTS BETWEEN CONTRACTOR AND PARTICIPATING PCPS;

LIST OF ANY PARTICIPATING SAFETY NET HOSPITALS, AND DOCUMENTATION DEMONSTRATING CONTRACTOR'S COMPLIANCE WITH THE REQUIREMENTS OF **SECTION 2.2.C**, INCLUDING BUT NOT LIMITED TO MODEL AND EXECUTED CONTRACTS BETWEEN CONTRACTOR AND PARTICIPATING SAFETY NET HOSPITALS AND DOCUMENTATION OF THE FINANCIAL PARTICIPATION AGREEMENTS INTERNAL TO PARTICIPATING SAFETY NET HOSPITALS' CORPORATE AFFILIATION, AS FURTHER SPECIFIED BY EOHHS;

MARKETING PLAN AND MARKETING MATERIALS AS DESCRIBED IN **SECTION 2.9**;

GRIEVANCE POLICIES AND PROCEDURES AS DESCRIBED IN **SECTION 2.6.A**; AND

ANY OTHER DOCUMENTATION AND MATERIALS REQUESTED BY EOHHS.

RESPONSIVENESS TO EOHHS

In addition to the other requirements of this Contract, Contractor shall ensure and demonstrate responsiveness to EOHHS requests related to this Contract, as follows:

PERFORMANCE REVIEWS

THE CONTRACTOR SHALL ATTEND REGULAR PERFORMANCE REVIEW MEETINGS HELD BY EOHHS AT EOHHS' OFFICES, OR AT ANOTHER LOCATION DETERMINED BY EOHHS, EACH QUARTER OR MORE FREQUENTLY IN EOHHS' DISCRETION;

THE CONTRACTOR SHALL ENSURE THAT KEY PERSONNEL AND OTHER STAFF WITH APPROPRIATE EXPERTISE ARE PRESENT IN PERSON AT SUCH MEETINGS, AS REQUESTED BY EOHHS, INCLUDING BUT NOT LIMITED TO CONTRACTOR'S MASSHEALTH EXECUTIVE DIRECTOR;

The Contractor shall prepare materials and information for such meetings as further directed by EOHHS, including but not limited to materials and information such as:

Reporting in a form and format approved by EOHHS on Contractor's performance under this Contract, including but not limited to measures such as:

Costs of care for Attributed Members;

Quality Measure performance;

Measures of utilization across categories of service and other indicators of changes in patterns of care;

Variation and trends in any such performance measures at the Participating PCP level;

DSRIP payments received and spent;

Completeness and validity of any data submissions made to EOHHS;

Opportunities the Contractor identifies to improve performance, and plans to improve such performance, including plans proposed to be implemented by the Contractor for Participating PCPs or other Affiliated Providers;

Changes in Contractor's staffing and organizational development;

Performance of Material Subcontractors including but not limited to any changes in or additions to Material Subcontractor relationships; and

Any other measures deemed relevant by Contractor or requested by EOHHS;

Updates and analytic findings from any reviews requested by EOHHS, such as reviews of data irregularities; and

Updates on any action items and requested follow-ups from prior meetings or communications with EOHHS;

The Contractor shall, within two business days following each performance review meeting, prepare and submit to EOHHS for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by EOHHS; Timely response to EOHHS requests.

Timely Response to EOHHS Requests

The Contractor shall respond to any EOHHS requests for review, analysis, information, or other materials related to Contractor's performance of this Contract by the deadlines specified by EOHHS, including but not limited to, for most requests such as those described in this Section, providing a sufficient response within one week of receiving the request. Such requests may include but are not limited to requests for:

Records or data to assist Contractor and EOHHS in identifying and resolving issues and inconsistencies in Contractor's data submissions to EOHHS;

Analysis of utilization, patterns of care, cost, and other characteristics to identify opportunities to improve Contractor's performance on any cost or quality measures related to this Contract or the Contractor's Approved ACO Agreements;

Documentation and information related to Contractor's care delivery, Care Management, or Community Partners responsibilities, to assist EOHHS with understanding Contractor's activities pursuant to these requirements;
Information about Contractor's Member Protections activities, including Grievances; and
Cooperation and coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor in any Fraud detection and control activities, or other activities as requested by EOHHS.

If the Contractor fails to satisfactorily respond within the time requested by EOHHS without prior approval from EOHHS for a late response, EOHHS may invoke the remedies for poor performance as described in **Section 5.22**.

Ad hoc Meetings

The Contractor shall attend ad hoc meetings at EOHHS' offices, or at another location determined by EOHHS, as requested by EOHHS;

The Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present in person at such meetings, as requested by EOHHS, including but not limited to Contractor's MassHealth Executive Director;

The Contractor shall prepare materials and information for such meetings as further directed by EOHHS.

Participation in EOHHS Efforts

As directed by EOHHS, the Contractor shall participate in any:

Efforts to promote the delivery of services in a Culturally and Linguistically Competent manner to all Attributed Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity;

Activities to verify or improve the accuracy, completeness, or usefulness of Contractor's data submissions to EOHHS, including but not limited to validation studies of such data;

Enrollment, disenrollment, or attribution activities related to this Contract;

Training programs;

Coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor;

Workgroups and councils, including but not limited to workgroups related to reporting or data submission specifications;

ACO learning collaboratives and other meetings or initiatives by EOHHS to facilitate information sharing and identify best practices among ACOs. The Contractor shall share information with EOHHS and others as directed by EOHHS regarding the Contractor's performance under this Contract, including but not limited to information on the Contractor's business practices, procedures, infrastructure, and information technology;

EOHHS efforts related to the development of policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, including substance use treatment related to the opioid epidemic and which facilitate access to appropriate BH services and timely discharge from the emergency department. Such policies or programs may include, but are not limited to, the development of:
Specialized inpatient services;
New diversionary and urgent levels of care;
Expanded substance use disorder treatment services; and
Services and supports tailored to populations with significant behavioral health needs, including justice involved and homeless populations;

Educational sessions for EOHHS staff, such as but not limited to trainings for EOHHS' Customer Service Center;

Site visits and other reviews and assessments by EOHHS; and

Any other activities related to this Contract.

Readiness Review Overview

EOHHS will conduct a Readiness Review of the Contractor that may include, at a minimum, one on-site review. This Readiness Review shall be conducted prior to the attribution of Members to the Contractor, and at other times during the Contract period at the discretion of EOHHS. EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become eligible for attribution to the Contractor.

The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

Staffing, including Key Personnel, in accordance with **Section 2.3.A**;

Marketing materials, in accordance with **Section 2.9**;

Capabilities of Material Subcontractors;

Care Management capabilities, in accordance with **Section 2.5.E**;

Content of Affiliated Provider contracts;

Contracts with Community Partners, in accordance with **Sections 2.8.A and 2.8.B**; and

Grievance procedures and other member protections, in accordance with **Section 2.6**.

Members shall not be considered Attributed Members of the Contractor unless and until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

EOHHS will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion, allow the Contractor to propose a plan to remedy all deficiencies prior to the Contract Operational Start Date.

EOHHS may, in its discretion, postpone the Contract Operational Start Date if the Contractor fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and EOHHS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

Alternatively, EOHHS may, in its discretion, consider MassHealth Members to be attributed the Contractor as of the Contract Operational Start Date provided the Contractor and EOHHS agree on a corrective action plan to remedy any deficiencies EOHHS identifies pursuant to this Section.

Contract Readiness Review Responsibilities

The Contractor shall:

Demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet all Contract requirements identified in the Readiness Review no later than 15 business days prior to the Contract Operational Start Date. The Contractor shall provide EOHHS with a certification, in a form and format specified by EOHHS, demonstrating such readiness;

At the request of EOHHS, provide to EOHHS or its designee, access to all facilities, sites, and locations at which one or more functions required under this Contract occurs or is performed;

At the request of EOHHS, provide to EOHHS or its designee, access to all information, materials, or documentation pertaining to the performance of any function required under this Contract within five business days of receiving the request; and

Provide EOHHS with a remedy plan within five business days after being informed of any deficiency EOHHS identifies during the Readiness Review. EOHHS, may, in its discretion, modify or reject any such remedy plan, in whole or in part.

The readiness provisions in this **Section 2.3** shall also apply, as determined appropriate by EOHHS, upon the implementation of changes in scope to this Contract and new programs or initiatives as described in **Sections 5.6 and 5.13** of this Contract, including but not limited to the introduction of LTSS and as further specified by EOHHS.

Approved ACO Agreements

Contracting MCOs

At all times after the Operational Start Date, the Contractor shall maintain an Approved ACO Agreement with one or more Contracting MCOs, as set forth in this Section. The Contracting MCOs shall be MassHealth MCOs that provide, or arrange for the provision of, covered services within the geographic area served by the Contractor, in EOHHS' determination. Such Approved ACO Agreements shall:

Be subject to review and prior approval by EOHHS;

Not in any way replace, modify, or invalidate any responsibilities the Contracting MCO has to EOHHS under the Contracting MCO's contract with EOHHS;

Obligate the Contractor to:

Comply with the requirements of **Section 2.5** for care delivery, care coordination, and Care Management;

Comply with the requirements of **Section 2.6** for Member Protections; and

Comply with the requirements of **Section 2.7** for TCOC accountability; and

Satisfy any other requirements specified by EOHHS.

Participating PCPs

Throughout the term of each Approved ACO Agreement, all of the Contractor's Participating PCPs shall be PCPs in the network of the Contracting MCO.

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

The Contractor's Approved ACO Agreements shall obligate the Contractor to ensure that, in addition to Members' other rights, all Attributed Members experience care that is integrated across providers, that is Member-centered, and that connects Attributed Members to the right care in the right settings, as described in this Section and as further specified by EOHHS.

General Care Delivery Requirements

Each of the Contractor's Approved ACO Agreements with a Contracting MCO shall delineate responsibilities and define areas of collaboration between the Contractor and the Contracting MCO, including obligating the Contractor as appropriate, to ensure that all Attributed Members receive care that is timely, accessible, and Culturally and Linguistically Competent, as set forth in this Section.

The Approved ACO Agreement shall obligate the Contractor to ensure that all Attributed Members may access:

As further specified by EOHHS, Primary Care or Urgent Care during extended hours to reduce avoidable inpatient admissions and emergency department visits;

Medical and diagnostic equipment that is accessible to the Attributed Member;

Care that is Culturally and Linguistically Competent. The Contractor shall regularly evaluate the population of Attributed Members to identify language needs, including needs experienced by Attributed Members who are deaf or hard of hearing, and needs related to health literacy, and to identify needs related to cultural appropriateness of care (including through the Care Needs Screening as described in **Section 2.5.B**. The Contractor shall identify opportunities to improve the availability of fluent staff or skilled translation services in Attributed Members' preferred languages and opportunities to improve the cultural appropriateness of Attributed Members' care;

All Medically Necessary services, including Behavioral Health Services, other specialty services, and any other services delivered to the Attributed Member by entities other than the Contractor, in a timely, coordinated, and person-centered manner and in accordance with the Attributed Member's wishes, as necessary and appropriate; and

The Approved ACO Agreement shall delineate responsibilities and define areas of collaboration between the Contractor and the Contracting MCO, including obligating the Contractor as appropriate, to:

Ensure each Attributed Member, including but not limited to Attributed Members with Special Health Care Needs, has access to providers with expertise in treating the full range of medical conditions of the Attributed Member;

Perform coordination to assist Attributed Members with accessing transportation to medical appointments, where Medically Necessary, for the Attributed Member to access medical care;

Ensure provision of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Preventive Pediatric Health Care Screening and Diagnosis (PPHSD) services to all Attributed Members under the age of 21;

Ensure the use of the CANS Tool by appropriately qualified Primary Care and Behavioral Health providers for all Attributed Members under the age of 21, as further directed by EOHHS, and otherwise ensure that Attributed Members under the age of 21 have access to appropriate care;

Ensure that all Attributed Members under the age of 21 have access to Medically Necessary services under the Children's Behavioral Health Initiative, including through partnering with Community Service Agencies, as identified by EOHHS. Such services shall include but not be limited to:
Intensive Care Coordination;
Family Support and Training Services;
In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring);
Therapeutic Mentoring Services;
In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support); and
Youth Mobile Crisis Intervention Services (MCI);

The Contractor shall ensure that criminal justice involved Attributed Members have access to medically necessary services, including Behavioral Health Services, and Care Management and care coordination as appropriate, as otherwise provided in this Contract;

Ensure that all Attributed Members have access to emergency Behavioral Health Services, including immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week;

Follow up with an Attributed Member within 24 hours of when the Attributed Members accesses emergency Behavioral Health Services, including ESP and MCI services;

Develop, implement, and maintain Wellness Initiatives as follows and as further directed by EOHHS:
Such Wellness Initiatives may include, but are not limited to, programs such as:
General health education classes, including how to access appropriate levels of health care;
Tobacco cessation programs, with targeted outreach for adolescents and pregnant women;
Childbirth education classes;
Nutrition counseling, with targeted outreach for pregnant women, older Attributed Members, and Attributed Members with Special Health Care Needs;
Education about the signs and symptoms of common diseases, conditions and complications (e.g., strokes, diabetes, depression);

Early detection of mental health issues in children;
Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;
Chronic disease self-management;
Prevention and treatment of alcohol and substance use disorders;
Coping with losses resulting from disability or aging;
Self-care training, including self-examination; and
Over-the-counter medication management, including the importance of understanding how to take over-the-counter and prescribed medications and how to coordinate all such medications.
The Contractor shall comply with all applicable state and federal statutes and regulations on Wellness Initiatives; and
The Contractor shall ensure that Wellness Initiatives include Culturally and Linguistically Appropriate materials.

Develop, implement, and maintain Disease Management programs as follows and as further directed by EOHHS:
The Contractor shall establish programs that address the specific needs of Attributed Members with certain diseases or conditions which may place such Attributed Members at high risk for adverse health outcomes;
Such programs may include activities such as but not limited to the following, as further directed by EOHHS:
Education of Attributed Members about their disease or condition, and about the care available and the importance of proactive approaches to the management of the disease or condition (including self-care);
Outreach to Attributed Members to encourage participation in the appropriate level of care and Care Management for their disease or condition;
Facilitation of prompt and easy access to care appropriate to the disease or condition in line with applicable and appropriate clinical guidelines;
Mechanisms designed to ensure that pre-treatment protocols, such as laboratory testing and drug pre-authorization, are conducted in a timely manner to ensure that treatment regimens are implemented as expeditiously as possible;
Education of providers, including, but not limited to, clinically appropriate guidelines and Attributed Member-specific information with respect to an Attributed Member's disease or condition, including relevant indicators; and
The Care Management activities described in Section 2.5.E;

Establish affiliations with providers (including Community Services Agencies (CSAs) in the Contractor's geographic area, as determined by EOHHS) and organizations as necessary to fulfill the requirements of this Section, including affiliations with CPs and other community-based organizations and social services organizations; and

Ensure appropriate care for Attributed Members with Special Health Care Needs.

The Contractor shall make best efforts to minimize boarding of Attributed Members in emergency departments as follows:

The Contractor shall work with the Contracting MCO to ensure timely access to medically necessary, clinically appropriate behavioral health services for Attributed Members determined by EOHHS to be disproportionately boarded in emergency departments, including, but not limited to, Attributed Members with:
Autism Spectrum Disorder (ASD);
Intellectual or Developmental Disabilities (IDD);
Dual diagnosis of mental health and substance use disorder;
Co-morbid medical conditions; and
Assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric hospital setting; and

In a form and format and at a frequency to be determined by EOHHS, the Contractor shall work with the Contracting MCO to ensure reporting to EOHHS on any Attributed Members awaiting placement in a 24-hour level of behavioral health care who remains in an emergency department for 24 hours or longer, as further specified by EOHHS.

Care Needs Screening and Appropriate Follow-Up

Each of the Contractor's Approved ACO Agreements with a Contracting MCO shall delineate responsibilities and define areas of collaboration between the Contractor and the Contracting MCO, including obligating the Contractor as appropriate, to ensure that Attributed Members receive screenings to identify their health and functional needs as follows:

The Approved ACO Agreement shall obligate the Contractor to assist the Contracting MCO to develop, implement, and maintain procedures for completing an initial Care Needs Screening for each Attributed Member, and to make best efforts to complete such screening within 90 days of the Attributed Member's Effective Date of Enrollment.

The Care Needs Screening shall:

Be a survey-based instrument approved by EOHHS;

Be made available to Attributed Members in multiple formats including Web, print and telephone;

Be conducted with the consent of the Attributed Member;

Include disclosures of how information will be used;

Incorporate, at a minimum, questions:
On member demographics;

On personal health history, including chronic illness and current treatment;
On self-perceived health status;
To identify Attributed Members with Special Health Care Needs;
To identify Attributed Members' needs for Culturally and Linguistically Appropriate Services, including but not limited to hearing and vision impairment and language preference;
To identify Attributed Members' needs for accessible medical diagnostic equipment;
To identify the Attributed Member's health concerns and goals; and
That specifically screen for care needs experienced by children, including evaluating characteristics of the Attributed Members' families and homes.

As further directed by EOHHS, evaluate Attributed Members' needs for Behavioral Health-related services, including unmet needs and including Attributed Members' appropriateness for assignment to BH CPs as further specified by EOHHS. The Care Needs Screening shall evaluate characteristics such as but not limited to:
The Attributed Member's current use of BH Services, if any, including substance use disorder treatment services;
The presence of mental health diagnoses or conditions, if any;
The presence of any substance use disorders, if any; and
The Attributed Member's affiliation with any state agency that provides BH-related care management or other activities, including the Department of Mental Health (DMH) and the Bureau of Substance Abuse Services (BSAS).

As further directed by EOHHS, evaluate Attributed Members' needs for LTSS and LTSS-related services, including unmet needs and including Attributed Members' appropriateness for assignment to LTSS CPs as further specified by EOHHS. The Care Needs Screening shall evaluate characteristics such as but not limited to:
Current use of MassHealth LTSS services that could be reasonably viewed as, such as:
Adult Day Health Services;
Adult Foster Care Services;
Continuous Skilled Nursing Services (post-100 days of services);
Day Habilitation Services;
Group Adult Foster Care Services;
Nursing Facility Services (post-100 days of services);
Inpatient and Outpatient Chronic Disease Rehabilitation Hospital Services (post-100 days of services); and
Personal Care Attendant Services (including Transitional Living Program);

Participation in a Home and Community Based Services (HCBS) Waiver;
Affiliation with any state agency that provides HCBS Waiver-like services, such as those provided by the Department of Developmental Services (DDS), Executive Office of Elder Affairs (EOEA), Massachusetts

Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing, or Massachusetts Rehabilitation Commission (MRC);
Need for assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs);
Risk for institutionalization;
Any other clinical presentation that indicates a potential need for LTSS care, such as an indicated necessity for home-based nursing; and
Whether the Attributed Member currently is the only adult in their home environment.

As further directed by EOHHS, evaluate Attributed Members' health-related social needs, including whether the Attributed Member would benefit from receiving community services to address health-related social needs. Such services shall include but not be limited to:
Housing stabilization and support services;
Housing search and placement;
Utility assistance;
Physical activity and nutrition; and
Support for Attributed Members who have experience of violence;

Evaluate Attributed Members' needs for care that is Culturally and Linguistically Competent, including identifying Attributed Members' preferred languages;

Evaluate relevant care needs of Attributed Members' family members, such as functional LTSS needs or Significant BH Needs including substance use disorders;

Evaluate whether an Attributed Member is an Attributed Member with Special Health Care Needs; and

Otherwise identify an Attributed Member's risk factors and relevant health and functional needs, as further directed by EOHHS.

The Approved ACO Agreement shall obligate the Contractor to assist the Contracting MCO to evaluate Attributed Members' needs through means other than the Care Needs Screenings. Such means shall include but not be limited to regular analysis of available claims, encounter, and clinical data on Attributed Members' diagnoses and patterns of care;

The Approved ACO Agreement shall obligate the Contractor to ensure that Attributed Members receive Medically Necessary and appropriate care and follow-up based on their identified needs, including but not limited to needs identified through the Care Needs Screening. The Contractor shall:

For Attributed Members with identified LTSS- or BH-related needs, coordinate as appropriate with the Contractor's CPs to fulfill the requirements of this Section, as described in **Sections 2.8.A and 2.8.B**;

Ensure that Attributed Members who are identified as having care needs as described in this Section receive assistance in accessing services to meet those needs. Such assistance shall include activities such as but not limited to:

Referring the Attributed Members to providers, social service agencies, or other community-based organizations that address the Attributed Member's needs, including but not limited to Medically Necessary services;
Providing the Attributed Member with support to ensure a successful referral, including:
Ensuring the Attributed Member attends the referred appointment, including activities such as coordinating transportation assistance and following up after missed appointments;
The Attributed Member's PCP communicating and sharing records with the provider being referred to, as appropriate to coordinate care; and
The Attributed Member's PCP directly introducing the Attributed Member to the service provider, if co-located, during a medical visit (i.e., a "warm hand-off");
Providing information and navigation to the Attributed Member regarding community providers of social services that address the Attributed Member's health-related social needs, as appropriate;
Providing the Attributed Member with information and impartial counseling about available options;
Coordinating with service providers and state agencies to improve integration of Attributed Members' care; and
Facilitating the transition of an Attributed Member to a different level of care, setting of care, frequency of care, or provider, to better match care to the Attributed Member's indicated needs;

Ensure that Attributed Members with Special Health Care Needs are comprehensively assessed and receive a Care Plan, as described in **Section 2.5.D**;

Shall develop, implement, and maintain policies and procedures regarding the identification of, outreach to, and assessment of Attributed Members with Special Health Care Needs within the required timeframe specified in **Section 2.5.D**;

Ensure that Attributed Members with identified LTSS needs receive appropriate services and referrals to address their care needs, which may include for certain Attributed Members referral to an LTSS CP or otherwise being comprehensively assessed and receiving a Care Plan, as described in **Section 2.5.D**;

Ensure that BH and LTSS CP-Assigned Attributed Members receive a Comprehensive Assessment and a Care Plan, as described in **Section 2.5.D**;

Ensure that all Attributed Members with Significant BH Needs, as further defined by EOHHS, receive appropriate services to address their care needs, as follows:
The Contractor shall:
Ensure all such Attributed Members receive appropriate services and referrals to address their care needs, which may include for certain Attributed Members as described in Section 2.5.D;
Work with Contractor's BH CPs to assist such Attributed Members with in accessing appropriate services, including but not limited to providing navigation and referral, as described in Section 2.8.A;

Ensure that Participating PCPs utilize a Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for Attributed Members with potential substance use disorder treatment needs as further directed by EOHHS;
Record in each such Attributed Member's medical record appropriate information on the Attributed Member's access to care, including but not limited to information on whether each Attributed Member has a Comprehensive Assessment, a Care Plan, a Care Coordinator or Clinical Care Manager assigned to their care, and sufficient access to ongoing support and treatment that meets the Attributed Member's care needs;
Report to EOHHS on such information and on Contractor's success in connecting such Attributed Members to appropriate levels of care, in aggregate form or as further directed by EOHHS; and
Ensure that each such Attributed Member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable;
Such services shall include but not be limited to services such as:
Behavioral Health Services including inpatient, diversionary, and outpatient care;
Substance use disorder treatment;
Peer Supports, recovery coaches, and self-help groups;
For Attributed Members under the age of 21, Children's Behavioral Health Initiative Services;
Community Support Program (CSP) services, including but not limited to CSP services for the chronically homeless; and
Services provided by other state agencies, including but not limited to DMH, DDS, DCF, and DYS.

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

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

The Approved ACO Agreement shall obligate the Contractor to perform care coordination as follows. The Contractor shall:

For Attributed Members with identified LTSS- or BH-related needs, coordinate as appropriate with Contractor's CPs to fulfill the requirements of this Section and as set forth in **Sections 2.8.A and 2.8.B**;

Coordinate care for all Attributed Members, including but not limited to:
Assisting Attributed Members to navigate to and access Medically Necessary services;
Facilitating communication between the Attributed Member and the Attributed Member's providers and among such providers, for example, through the use of the Mass HIway;
Monitoring the provision of services and making necessary referrals; and

Coordinating with staff in other state agencies, or community service organizations, if the agency or organization is already involved in serving the Attributed Member, or providing information and referral if the agency or organization may be helpful in meeting such needs;

Ensure that all Attributed Members receive information about how to contact the Contractor to access care coordination; and

Ensure that in the process of coordinating care, each Attributed Member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable;

The Approved ACO Agreement shall obligate the Contractor to have a Transitional Care Management program. Contractor shall develop, implement, and maintain protocols for Transitional Care Management with all Affiliated Hospitals. Such protocols shall:

Ensure follow-up with an Attributed Member within 72 hours of when the Attributed Member is discharged from any type of Affiliated Hospital inpatient stay or emergency department visit, through a home visit, in-office appointment, telehealth visit, or phone conversation, as appropriate, with the Attributed Member;

Ensure post-discharge activities are appropriate to the needs of the Attributed Member, including identifying the need for follow-up services;

Be developed in partnership with and specify the role of Contractor's BH CPs and LTSS CPs in managing transitional care for Attributed Members with BH and LTSS needs;

Integrate Contractor's other Care Management activities for Attributed Members, such as ensuring that an Attributed Member's Care Coordinator or Clinical Care Manager is involved in discharge planning and follow-up;

Include elements such as but not limited to the following:
Event notification protocols that ensure key providers and individuals involved in an Attributed Member's care are notified of admission, transfer, discharge, and other important care events, for example, through the use of the Mass HIway and the Mass HIway Event Notification Service (ENS). Such key providers shall include but not be limited to an Attributed Member's PCP, BH provider if any, and LTSS provider (e.g., Personal Care Attendant) if any;
Medication reconciliation;
Criteria that trigger an in-person rather than telephonic post-discharge follow-up;
Home visits post-discharge for certain Attributed Members with complex needs;
Policies and procedures to ensure inclusion of Attributed Members and Attributed Members' family members, guardians and caregivers, as applicable, in discharge planning and follow-up, and to ensure appropriate education of Attributed Members, family members, guardians, and caregivers on post-discharge care instructions; and

Inclusion of the Attributed Member's BH provider, if any, and LTSS provider (e.g., Personal Care Attendant) if any in discharge planning and follow-up;

Include protocols for documenting all efforts related to Transitional Care Management, including the Attributed Member's active participation in any discharge planning;

The Approved ACO Agreement shall obligate the Contractor to assist the Contracting MCO to ensure that the Contracting MCO's Clinical Advice and Support Line is accessible by Attributed Members 24 hours a day, seven days a week and facilitates coordination of Attributed Member care as follows:

The Clinical Advice and Support Line's clinicians shall have access to information about Attributed Members and providers, including, at a minimum:
Processes and capabilities to identify an Attributed Member who calls the Clinical Advice and Support Line;
The name, contact information, and hours of operation of the Attributed Member's Participating PCP; and
The name and contact information of the Attributed Member's Care Coordinator or Clinical Care Manager, if applicable.

The Clinical Advice and Support Line shall be incorporated in Contractor's policies and procedures for care coordination and Care Management, such as policies and procedures for:
The Clinical Advice and Support Line notifying providers and Care Management staff involved in an Attributed Member's care of a phone call, particularly if the call indicates a need to modify the Attributed Member's documented Care Plan or course of treatment or a need for follow-up;
The Clinical Advice and Support Line's clinicians being able to access relevant information from an Attributed Member's Care Plan or medical record under certain circumstances to respond to an Attributed Member's questions and to coordinate care; and
The Clinical Advice and Support Line providing appropriate information and navigation to Attributed Members to providers who can support an Attributed Member's needs, including but not limited to Affiliated Providers and providers involved in an Attributed Member's care.

The Clinical Advice and Support Line shall otherwise coordinate with an Attributed Member's Participating PCP, Care Coordinator, or Clinical Care Manager, as applicable, including through providing "warm handoffs" to such individuals through direct transfer protocols and processes and capabilities to share information with such individuals.

Assessment and Member-Centered Care Planning

Each of the Contractor's Approved ACO Agreements with a Contracting MCO shall obligate the Contractor to ensure that certain Attributed Members, as described in this Section and further specified by EOHHS, are comprehensively assessed and receive a documented Care Plan that is informed by such assessment. Such Comprehensive Assessment and documented Care Plan shall be member-centered and shall inform Attributed Members' care, including but not limited to any Care Management activities, as described in this Section and further specified by EOHHS.

Each of the Contractor's Approved ACO Agreements shall obligate the Contractor to comprehensively assess certain Attributed Members as follows:

Contractor shall either directly or, as appropriate, through its Community Partners, at a minimum, comprehensively assess:
LTSS CP-Assigned Attributed Members;
BH CP-Assigned Attributed Members. For any such BH CP-Assigned Attributed Members, the Contractor shall obligate the Contractor's BH CPs to comprehensively assess such Attributed Members; and
Attributed Members with Special Health Care Needs;

The Contractor shall ensure that Attributed Members are comprehensively assessed using a person-centered assessment of an Enrollee's care needs and, as applicable and clinically appropriate, the Enrollee's functional needs, accessibility needs, goals, and other characteristics, taking into consideration the domains in **Section 2.5.D.1.l**;

The Contractor shall ensure that BH and LTSS CP-Assigned Attributed Members are comprehensively assessed within 90 days of the effective date of each such Attributed Member's assignment to a BH or LTSS CP;

The Contractor shall ensure that Attributed Members with Special Health Care Needs are comprehensively assessed within 180 days of their enrollment date in Contract Year 1, and the Contractor shall ensure that Attributed Members with Special Health Care Needs enrolled in each subsequent year are comprehensively assessed within 90 days of enrollment;

The Contractor shall update such assessments at least annually thereafter, and whenever an Attributed Member experiences a major change in more than one area of health status that is not temporary or episodic, and requires interdisciplinary review or revision of the Attributed Member's Care Plan;

The Contractor shall record such assessments in Attributed Members' health record;

Such assessments shall be performed using assessment tools and methods as approved by EOHHS;

The Contractor shall ensure that such assessments are completed independently, by an individual who is not financially or otherwise conflicted, as further defined by EOHHS;

The Contractor shall respond to requests by EOHHS or EOHHS' designee (e.g. EOHHS' Third Party Administrator (TPA)) for copies of the assessments of Attributed Members seeking Long-Term Services and Supports as follows and as further specified by EOHHS:
For such Attributed Members for whom such assessment has been completed, the Contractor shall provide a copy of such assessment as specified by EOHHS;

For such Attributed Member for whom no such assessment has been completed, the Contractor shall provide the Attributed Member's Care Needs Screening information or other information as specified by EOHHS;
The Contractor shall designate an individual to receive such requests and shall supply contact information for that individual to EOHHS;

As further directed by EOHHS, the Contractor may, where appropriate, meet the assessment requirement, as described in **Section 2.5.D**, with an existing assessment for an Attributed Member rather than conducting a new assessment, where such existing assessment is timely and appropriate, as further defined by EOHHS;

As requested by EOHHS, the Contractor shall report, in a form and format as specified by EOHHS, such assessments in accordance with **Appendix F**;

Comprehensive Assessments for BH and LTSS CP-Assigned Attributed Members
The Contractor shall provide, either directly or, as appropriate through its Community Partners, a Comprehensive Assessment, as further specified by EOHHS, to LTSS CP-Assigned Attributed Members and BH CP-Assigned Attributed Members;
Comprehensive Assessments, as provided to BH and LTSS CP-Assigned Attributed Members, shall include domains and considerations appropriate for the population receiving the Comprehensive Assessment, as further specified by EOHHS, and may include, but may not be limited to, the following domains and considerations as they relate to the Attributed Member:
Immediate care needs and current services, including but not limited to any care coordination or management activities and any services being provided by state agencies such as DMH, DDS, MRC, MCB, DCF, DYS, or EOEA;
Health conditions;
Medications;
Ability to communicate their concerns, symptoms, or care goals;
Functional status, including needs for assistance with any Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs);
Self-identified strengths, weaknesses, interests, choices, care goals, and personal goals;
Current and past mental health needs and substance use;
Accessibility requirements, including but not limited to preferred language and specific communication needs, transportation needs, and equipment needs;
Housing and home environment, including but not limited to risk of homelessness, housing preferences, and safety;
Employment status, interests, and goals, as well as current use of and goals for leisure time;
Available informal, caregiver, or social supports, including peer supports;
Risk factors for abuse or neglect;
Food security, nutrition, wellness, and exercise;
Advance directives status and preferences and guardianship status; and

Other domains and considerations identified by EOHHS.

EOHHS may specify such Comprehensive Assessment tool, at EOHHS' discretion;

Such Comprehensive Assessments shall be appropriate to the Attributed Member, shall be Attributed Member-centered and shall take place in a location that meets the Attributed Member's needs, including home-based assessments as appropriate;

Such Comprehensive Assessments shall incorporate an assessment of the Attributed Member's functional needs for LTSS, as further specified by EOHHS;

Each of the Contractor's Approved ACO Agreements shall obligate the Contractor to provide certain Attributed Members with documented Care Plans as follows:

The Contractor shall, at a minimum, provide either directly or, as appropriate, through its Community Partners, documented Care Plans to:
LTSS Assigned Attributed Members. For any such LTSS-Assigned Attributed Members, the Contractor shall obligate the Contractor's LTSS CPs to complete the LTSS component of such Care Plan;
BH CP-Assigned Attributed Members. For any such BH CP-Assigned Attributed Members, the Contractor shall obligate the Contractor's BH CPs to provide such Care Plans; and
Attributed Members with Special Health Care Needs;

Such Care Plans shall:
Be based on an Attributed Member's Comprehensive Assessment, or other assessment as described in **Section 2.5.D.1**, and developed under the direction of the Attributed Member (or the Attributed Member's representative, if applicable);
Reflect the Attributed Member's preference and needs;
Be updated periodically to reflect changes in the Attributed Member's needs, health status, or course of treatment. The Attributed Member shall be at the center of the care planning process;
Designate the Attributed Member's care team, as applicable, including participants of the Attributed Member's choosing;
Be signed or otherwise approved by the Attributed Member. Contractor shall establish and maintain policies and procedures to ensure an Attributed Member can sign or otherwise convey approval of his or her Care Plan when it is developed or subsequently modified. Such policies and procedures shall include:
Informing an Attributed Member of his or her right to approve the Care Plan;
Providing the Attributed Member with a copy of the Care Plan;
Providing mechanisms for the Attributed Member to sign or otherwise convey approval of the Care Plan. Such mechanisms shall meet the Attributed Members accessibility needs; and
Working with the Contracted MCO to ensure that the Attributed Member has been informed of the availability and access to Ombudsman services.
Be approved and signed by the Attributed Member's PCP or PCP Designee in a timely manner, as further specified by EOHHS. Such approval shall include, but shall not be limited to, approval of Care Plans

COMPLETED BY THE CONTRACTOR'S BH CPS AND APPROVAL OF THE LTSS COMPONENT OF CARE PLANS COMPLETED BY THE CONTRACTOR'S LTSS CPS, AS FURTHER SPECIFIED BY EOHHS.

CARE MANAGEMENT

Each of the Contractor's Approved ACO Agreements with a Contracting MCO shall delineate responsibilities and define areas of collaboration between the Contractor and the Contracting MCO, including obligating the Contractor as appropriate, to provide Care Management activities to appropriate Attributed Members as described in this Section and further specified by EOHHS.

THE APPROVED ACO AGREEMENT SHALL DELINEATE RESPONSIBILITIES AND DEFINE AREAS OF COLLABORATION BETWEEN THE CONTRACTOR AND THE CONTRACTING MCO TO, AND SHALL OBLIGATE THE CONTRACTOR TO ASSIST THE CONTRACTING MCO TO, PROACTIVELY IDENTIFY CERTAIN ATTRIBUTED MEMBERS WHO MAY BENEFIT FROM CARE MANAGEMENT ACTIVITIES BASED ON THE RESULTS OF A SYSTEMATIC EVALUATION AS DESCRIBED IN THIS SECTION. SUCH EVALUATION SHALL:

EXPLICITLY INCORPORATE, AT A MINIMUM:
ATTRIBUTED MEMBERS WITH SPECIAL HEALTH CARE NEEDS;
ATTRIBUTED MEMBERS WITH LTSS NEEDS, AS INDICATED BY THE RESULTS OF THE CARE NEEDS SCREENING DESCRIBED IN **SECTION 2.5.B.2.G**;
ATTRIBUTED MEMBERS WHO ARE IDENTIFIED BY EOHHS AS POTENTIALLY IN NEED OF CARE MANAGEMENT;
ATTRIBUTED MEMBERS WHO ARE IDENTIFIED BY PCPS AS POTENTIALLY IN NEED OF CARE MANAGEMENT; AND
ATTRIBUTED MEMBERS WHO SELF-IDENTIFY TO THE CONTRACTOR AS POTENTIALLY IN NEED OF CARE MANAGEMENT;

INCORPORATE INFORMATION CONTAINED, IF APPLICABLE AND AS AVAILABLE, IN EACH ATTRIBUTED MEMBER'S:
CARE NEEDS SCREENING;
CLAIMS OR ENCOUNTER DATA;
MEDICAL RECORDS;
LABORATORY RESULTS;
PHARMACY DATA;
DISCHARGE DATA; AND
OTHER RELEVANT SOURCES OF INFORMATION IDENTIFIED BY THE CONTRACTOR OR EOHHS; AND

INCORPORATE PREDICTIVE MODELING OF AN ATTRIBUTED MEMBER'S RISK FOR HIGH COST, HIGH UTILIZATION, ADMISSION, RE-ADMISSION, OR OTHER ADVERSE HEALTH OUTCOMES.

THE APPROVED ACO AGREEMENT SHALL OBLIGATE THE CONTRACTOR TO PROVIDE EACH IDENTIFIED ATTRIBUTED MEMBER WITH CARE MANAGEMENT AS FOLLOWS:

CARE MANAGEMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, ACTIVITIES SUCH AS:
PROVIDING A COMPREHENSIVE ASSESSMENT AS DESCRIBED IN **SECTION 2.5.D.1** FOR ATTRIBUTED MEMBERS ASSIGNED TO A BH OR LTSS CP;
OTHERWISE COMPREHENSIVELY ASSESSING ATTRIBUTED MEMBERS WITH SPECIAL HEALTH CARE NEEDS AS DESCRIBED IN **SECTION 2.5.D**;

Creating a documented Care Plan as described in **Section 2.5.D.2** and updating such Care Plan at least annually;
Providing a Care Coordinator or Clinical Care Manager who is assigned to the Attributed Member's care;
Designating a care team of providers and other individuals involved in the Attributed Member's care. The care team shall include, at a minimum:
The Attributed Member's Care Coordinator or Clinical Care Manager;
The Attributed Member's PCP;
The Attributed Member's Behavioral Health provider (if applicable) or Contractor's BH CP, as appropriate;
The Attributed Member's LTSS provider (if applicable) or Contractor's LTSS CP, as appropriate; and
Any additional individual requested by the Attributed Member;
Providing team-based Care Management, including meetings of the care team at least annually and after any major events in the Attributed Member's care or changes in health status, or more frequently if indicated.

The Contractor shall develop, implement, and maintain criteria and protocols for determining which Care Management activities may benefit an Attributed Member;

The Contractor shall, at a minimum:
Provide a Care Coordinator who is assigned to the Attributed Member's care for any Attributed Member with Special Health Care Needs, who is a BH CP-Assigned Attributed Members, or who is an LTSS CP Assigned Attributed Member;
Provide a Clinical Care Manager who is assigned to the Attributed Member's care and a documented Care Plan based on a Comprehensive Assessment, or other assessment as described in **Section 2.5.D**, for any Attributed Member receiving Care Management and identified by the Contractor or EOHHS as at risk for adverse care events; and
Coordinate with Contractor's BH CPs to perform outreach and engagement to any BH CP-Assigned Attributed Member, and to provide Care Management to any BH CP-Engaged Attributed Member, as described in **Section 2.8.A**.

The Contractor shall develop, implement, and maintain procedures for providing, and shall provide, Care Management as follows:
The Contractor's Care Management procedures shall:
Be approved by EOHHS;
Include procedures for acquiring and documenting Attributed Members' consent to receive Care Management and for the Contractor to share information about an Attributed Member's care with Attributed Members' providers to promote coordination and integration. Contractor shall make best efforts to obtain such consent;
Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for Care Coordinators, Clinical Care Managers, and other staff involved in Care Management activities in line with industry practices;

Include processes for the Contractor to measure the effectiveness and quality of the Contractor's Care Management procedures. Such processes shall include:

Identification of relevant measurement process or outcomes; and

Use of valid quantitative methods to measure outcomes against performance goals;

Include protocols for providing Care Management activities in each of the following settings. The Contractor shall exercise best efforts to provide Care Management in such settings:

At adult and family shelters, for Attributed Members who are homeless;

The Attributed Member's home;

The Attributed Member's place of employment or school;

At foster home, group homes and other residential placements especially for children in the care or custody of DCF and youth affiliated with DYS;

At day health sites, such as for Adult Day Health;

24-hour level of care facilities for Behavioral Health or substance use disorder treatment; or

Another setting of the Attributed Member's choosing;

Include criteria and protocols for discharging Attributed Members from Care Management;

Ensure that the Care Management activities each Attributed Member is receiving are appropriately documented as further specified by EOHHS; and

Ensure regular contacts between Care Management staff, the Attributed Member's PCP, and the Attributed Member.

For Attributed Members assigned to a BH or LTSS CP, Contractor shall coordinate with Contractor's CPs for the provision of any Care Management activities to Attributed Members, as described in **Sections 2.8.A and 2.8.B**, and Contractor shall ensure that Contractor's CPs are providing expertise and informing the development of Contractor's Care Management policies, procedures, and programs.

Member Protections

Each of the Contractor's Approved ACO Agreements with a Contracting MCO shall obligate the Contractor to:

Receipt and Timely Resolution of Attributed Members' Grievances

The Contractor shall assist the Contracting MCO to ensure the receipt and timely resolution of Attributed Members' Grievances, including assisting the Contracting MCO to:

Within 30 days of the Operational Start Date, provide Attributed Members information on the Contractor's Grievance procedures, including the right to file Grievances, the requirements and timeframes for filing and resolving a Grievance, and the availability of assistance in the filing process;

Notify Attributed Members of their access to the EOHHS Appeals and Ombudsman processes, and not in any way attempt to limit an Attributed Member's access or utilization of said processes;

Notify Attributed Members of the receipt, orally or in writing, of a Grievance within two (2) business days of receipt of said Grievance; and

Resolve and notify Attributed Members of the outcome of a Grievance proceeding within thirty (30) calendar days from the date the Contractor received the Grievance, either orally or in writing, from the Attributed Member or their representative.

Referrals and Emergency Services

The Contractor shall ensure that Attributed Members are not limited to obtaining services only from Affiliated Providers. The Contractor shall:

Ensure Participating PCPs make referrals to any provider, as appropriate, regardless of the provider's affiliation with the Contractor. The Contractor shall not restrict Participating PCPs from making referrals to providers who are not Affiliated Providers;

Not impose additional requirements for referrals to providers who are not Affiliated Providers;

Not impede Attributed Members' access to or freedom of choice of providers;

Not reduce or impede access to Medically Necessary services; and

Ensure that Attributed Members may obtain emergency services from any provider, regardless of its affiliation with the Contractor, including but not limited to receiving services from ESP or MCI providers.

Written Materials

Unless otherwise provided in this Contract, the Contractor shall ensure that all written materials provided by the Contractor to Attributed Members are:

CULTURALLY APPROPRIATE, REFLECTING THE DIVERSITY OF THE CONTRACTOR'S MEMBERSHIP;

PRODUCED IN A MANNER, FORMAT, AND LANGUAGE THAT MAY BE EASILY UNDERSTOOD BY PERSONS WITH LIMITED ENGLISH PROFICIENCY;

TRANSLATED INTO PREVALENT LANGUAGES OF THE CONTRACTOR'S MEMBERSHIP;

MADE AVAILABLE IN ALTERNATIVE FORMATS UPON REQUEST, INCLUDING VIDEO AND AUDIO; AND

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 ATTRIBUTED MEMBER MAY OBTAIN HELP WITH GETTING THE MATERIALS TRANSLATED.

ORIENTATION PACKET

As further specified by EOHHS, coordinate with the Contracting MCO to provide each Attributed Member with an Orientation Packet. The Contractor or Contracting MCO shall submit such Orientation Packet to EOHHS for prior approval, and such Orientation Packet shall contain, at a minimum, information on:

ATTRIBUTED MEMBERS' RIGHTS, AS DESCRIBED IN **SECTION 2.6.H**;

GRIEVANCE PROCEDURES, AS DESCRIBED IN **SECTION 2.6.A**;

THE CONTRACTOR'S RESPONSIBILITIES, AS SET FORTH IN THIS CONTRACT;

THE CONTRACTOR'S BH CPS AND LTSS CPS;

THE AVAILABILITY OF AND ACCESS TO OMBUDSMAN SERVICES, INCLUDING THE CONTACT INFORMATION FOR THE OMBUDSMAN; AND

ANY OTHER INFORMATION AS SPECIFIED BY EOHHS.

ORAL INTERPRETATION SERVICES

The Contractor shall make oral interpretation services for all non-English languages available free of charge to Members and notify Members of this service and how to access it.

WEBSITE INFORMATION

The Contractor shall post on its website in a prominent place, in multiple languages and formats:

THE ORIENTATION PACKET;

CONTACT INFORMATION FOR EOHHS' OMBUDSMAN;

A METHOD FOR SUBMITTING INQUIRIES, PROVIDING FEEDBACK, AND INITIATING GRIEVANCES, INCLUDING FOR ATTRIBUTED MEMBERS WHO DO NOT HAVE ACCESS TO EMAIL;

THE IDENTITY, CONTACT INFORMATION, ADDRESSES, OPERATING HOURS, QUALIFICATIONS, AND AVAILABILITY OF THE CONTRACTOR'S AFFILIATED PROVIDERS;

HOW ATTRIBUTED MEMBERS MAY ACCESS ORAL INTERPRETATION SERVICES FREE-OF-CHARGE IN ANY NON-ENGLISH LANGUAGE SPOKEN BY ATTRIBUTED MEMBERS;

HOW ATTRIBUTED MEMBERS MAY ACCESS WRITTEN MATERIALS IN PREVALENT LANGUAGES AND ALTERNATIVE FORMATS; AND

ADDITIONAL INFORMATION AS SPECIFIED BY EOHHS.

DISENROLLMENT

The Contractor shall not request that EOHHS disenroll an Attributed Member from a Contracting MCO for any reason, not influence in any way a Participating PCP or a Contracting MCO such that the Participating PCP or Contracting MCO requests that EOHHS disenroll an Attributed Member from a Contracting MCO, and not request that EOHHS disenroll an Attributed Member from a Contracting MCO on behalf of the Contracting MCO.

WRITTEN POLICIES REGARDING ATTRIBUTED MEMBERS' RIGHTS

The Contractor shall coordinate with the Contracting MCO to provide Attributed Members with, and have written policies ensuring Attributed Members are guaranteed, the following rights, and ensure that the Contractor's employees and Material Subcontractors observe and respect these rights:

THE RIGHT TO RECEIVE WRITTEN INFORMATION IN ACCORDANCE WITH **SECTION 2.6.C**;

THE RIGHT TO BE TREATED WITH RESPECT AND WITH DUE CONSIDERATION FOR HIS OR HER DIGNITY AND PRIVACY;

THE RIGHT TO BE AFFORDED PRIVACY AND CONFIDENTIALITY IN ALL INTERACTIONS WITH THE CONTRACTOR AND ITS AFFILIATED PROVIDERS, UNLESS OTHERWISE REQUIRED BY LAW;

THE RIGHT TO RECEIVE INFORMATION ON AVAILABLE TREATMENT OPTIONS AND ALTERNATIVES, PRESENTED IN A MANNER APPROPRIATE TO THE ATTRIBUTED MEMBER'S CONDITION, CULTURE, FUNCTIONAL STATUS, LANGUAGE NEEDS, REQUIRED MODES OF COMMUNICATION, AND OTHER ACCESSIBILITY NEEDS;

THE RIGHT TO PARTICIPATE IN ALL ASPECTS OF CARE AND TO EXERCISE ALL RIGHTS OF APPEAL;

THE RIGHT TO BE FULLY INVOLVED IN MAINTAINING THEIR HEALTH AND MAKING DECISIONS ABOUT THEIR HEALTH CARE, INCLUDING THE RIGHT TO REFUSE TREATMENT IF DESIRED, AND TO BE APPROPRIATELY INFORMED AND SUPPORTED TO THIS END;

The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with applicable federal law;

The right to request and receive any of their medical records in the Contractor's possession, and be notified of the process for requesting amendments or corrections to such records;

The right to freely exercise their rights set forth in this Section and not have the exercise of those rights adversely affect the manner in which the Contractor or any Affiliated Provider treats the Attributed Member;

The right to be notified of these rights and considerations at least annually, in a manner that they can understand, that takes into consideration their culture, functional status, language needs, and required modes of communication. This right shall include the right to request and obtain the information listed in the Orientation Packet at least once per year, and the right to receive notice of any significant change in the information provided in the Orientation Packet at least 30 days prior to the intended effective date of the change;

The right to not be discriminated against because of their race, ethnicity, national origin, religion, sex, gender identity, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment, per Section 1557 of the Affordable Care Act (ACA);

The right to have all the Contractor's options and rules fully explained to them, including through use of a qualified interpreter or alternate communication mode if needed or requested;

The right to choose a plan and provider that they qualify for at any time during their annual plan selection period, including disenrolling from a Contracting MCO and enrolling in a MassHealth ACO, another MassHealth-contracted MCO, or the MassHealth PCC Plan;

The right to receive timely information about changes to the benefits or programs offered by the Contractor at least 30 days prior to the intended date of the change;

The right to designate a representative if they are unable to participate fully in treatment decisions. This includes the right to have translation services available to make information appropriately accessible to them or to their representative;

The right to receive a copy of and to approve their Care Plan, if any;

The right to expect timely, accessible, Culturally and Linguistically Competent, and evidence-based treatments;

The right to obtain emergency care 24 hours a day, seven days a week from any hospital or other emergency care setting;

THE RIGHT TO DETERMINE WHO IS INVOLVED IN THEIR CARE TEAM, INCLUDING FAMILY MEMBERS, ADVOCATES, OR OTHER PROVIDERS OF THEIR CHOOSING;

THE RIGHT TO RECEIVE A SECOND OPINION ON A MEDICAL PROCEDURE;

THE RIGHT TO EXPERIENCE CARE AS DESCRIBED IN THIS CONTRACT, INCLUDING TO RECEIVE A CARE NEEDS SCREENING AND APPROPRIATE FOLLOW-UP;

THE RIGHT TO HAVE ADVANCE DIRECTIVES EXPLAINED AND TO ESTABLISH THEM;

THE RIGHT TO FILE GRIEVANCES AS DESCRIBED IN THIS CONTRACT, AND THE RIGHT TO ACCESS EOHHS' APPEALS PROCESSES; AND

THE RIGHT TO BE PROTECTED FROM LIABILITY FOR PAYMENT OF ANY FEES THAT ARE THE OBLIGATION OF THE CONTRACTOR;

DISCRIMINATION POLICY

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

ACCESS TO EMERGENCY SERVICES PROGRAM AND MOBILE CRISIS INTERVENTION SERVICES

The Contractor shall facilitate Attributed Members' immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week.

Other

The Contractor shall otherwise provide Attributed Members with care in accordance with Contractor's responsibilities under **Section 2.5** of this Contract.

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

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

Contracting MCO and EOHHS Involvement in TCOC Calculation

EOHHS will calculate and provide the Contracting MCO with values related to the TCOC calculations for the Contractor. The Contracting MCO shall, for all calculations described in **Section 2.7**, use such values or other amounts calculated and provided to the Contracting MCO by EOHHS.

The Contracting MCO shall provide EOHHS with any requested information or assistance in calculating such values.

Values related to the TCOC calculation shall include but may not be limited to:

The Contractor's TCOC Benchmark;

The Contractor's TCOC Performance;

The Contractor's Quality Score;

The Contractor's Shared Savings or Shared Losses payment, as modified by the Contractor's Quality Score; and

Other values as specified by EOHHS.

Optional RC II Adult Risk Sharing Arrangement

For each Region and Rating Category II Adult (hereinafter referred to as "RCII Adult "), the Contractor shall have the option to elect to share risk with EOHHS for the Non-HCV Medical Component of the TCOC Benchmark in accordance with the following provisions. EOHHS shall specify, prior to the Operational Start Date, the date, form, and format by which the Contractor shall make such election. Should the Contractor elect to share risk with EOHHS in this way, the Contractor's arrangement with EOHHS shall hereinafter be referred to as "the Contractor's Chosen RC II Adult Risk Sharing Arrangement."

All Regions selected by the Contractor for the Contractor's Chosen RCII Adult Risk Sharing Arrangement (hereinafter referred to as "Selected RCII Adult Regions") shall be excluded from the Contractor's aggregate non-HCV TCOC Benchmark for the purposes of performing Shared Savings/Shared Losses calculations described in **Section 2.7.F.2.**

Selected RC II Adult Regions shall be included for the purposes of performing Shared Savings/Shared Losses calculations described in **Section 2.7.F.3**.

Shared Savings or Shared Losses Payment Calculations

The Contractor's Shared Savings or Shared Losses payment for each Contract Year shall be calculated as follows:

The Contractor's TCOC Benchmark shall be calculated as described in **Section 2.7.E.2**;

The Contractor's TCOC Performance shall be calculated as described in **Section 2.7.E.2**;

If the difference when the Contractor's TCC Performance is subtracted from the Contractor's Benchmark is equal to an amount greater than zero (0), such difference shall be the Contractor's Savings. If such difference is equal to an amount less than zero (0), such difference shall be the Contractor's Losses. If such difference equals zero (0) and Contractor's TCOC Performance and TCOC Benchmark are equal to each other, Contractor shall have neither Savings nor Losses for the Contract Year; and

If Contractor has Savings or Losses, the Contractor's Shared Savings payment amount or Contractor's Shared Losses payment amount, respectively, shall be calculated based on Contractor's Risk Track, as described in **Section 2.7.D**, and based on Contractor's Quality Score, as described in **Section 2.7.E**. If Contractor has neither Savings nor Losses for the Contract Year, Contractor shall have neither a Shared Savings payment nor a Shared Losses payment.

Risk Tracks

The Contractor shall, prior to the Operational Start Date or other date as determined by EOHHS, select Contractor's Risk Track for the Non-HCV component of the TCOC Benchmark and notify EOHHS in writing of such selection. Contractor's Risk Track for the Non-HCV component of the TCOC Benchmark shall be Risk Track 1 – Limited Accountability (as described in **Section 2.7.D.2.b**), Risk Track 2 – Moderate Accountability (as described in **Section 2.7.D.2.c**), or Risk Track 3 – Increased Accountability (as described in **Section 2.7.D.2.d**). As further specified by EOHHS, the Contractor may annually change the Contractor's Risk Track prior to the start of a Contract Year, as approved in writing by EOHHS. The Contractor may not change the Contractor's Risk Track prior to the start of Contract Year 1;

Risk Tracks for the Non-HCV component of the TCOC Benchmark, as defined in **Section 2.7.F.2.g**, shall be applied as follows:

Shared Savings and Shared Losses payments for the Non-HCV component of the TCOC Benchmark shall be calculated subject to the following risk corridor provisions:

The minimum savings and losses rate shall both be equal to either one percent (1%) or two percent (2%) of the Non-HCV component of the TCOC Benchmark, as chosen by the Contractor in advance of each Contract Year through a defined process and according to a timeline specified by EOHHS. If Contractor's Savings or the absolute value of the Contractor's Losses are less than 2% of the Non-HCV component of the TCOC Benchmark, there shall be no Shared Savings or Shared Losses payment. The Contractor shall choose its minimum savings and losses percentage for each Contract Year by a date specified by EOHHS. The Contractor may not change the Contractor's chosen minimum savings and losses percentage until the process begins for the next Contract Year;

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

Risk Track 1 – Limited Accountability

If Contractor selects Risk Track 1 – Limited Accountability, then subject to the provisions in **Section 2.7.D.2.a** above, Contractor's Shared Savings payment or Shared Losses payment, prior to modifying for Contractor's Quality Score as described in **Section 2.7.E** below, shall be as follows:

If Contractor has Savings less than or equal to three percent (3%) of the Non-HCV component of the TCOC Benchmark:

In Contract Year 1, Shared Savings shall be twenty percent (20%) of Savings;

In Contract Year 2, Shared Savings shall be twenty-five percent (25%) of Savings;

In Contract Years 3-5, Shared Savings shall be thirty percent (30%) of Savings;

If Contractor has Savings greater than three percent (3%) of the Non-HCV component of the TCOC Benchmark, Contractor's additional Shared Savings payment for the amount of Savings above three percent (3%) of the Non-HCV component of the TCOC Benchmark shall be equal to:

In Contract Year 1, additional Shared Savings shall be ten percent (10%) of such additional Savings;

In Contract Year 2, additional Shared Savings shall be twelve and one half percent (12.5%) of such additional Savings; and

In Contract Years 3-5, additional Shared Savings shall be fifteen percent (15%) of such additional Savings;

If Contractor has Losses with absolute value less than or equal to three percent (3%) of the Non-HCV component of the TCOC Benchmark:

In Contract Years 1-3, Shared Losses shall be twenty percent (20%) of Losses; and
In Contract Years 4-5, Shared Losses shall be thirty percent (30%) of Losses;
If Contractor has Losses with absolute value greater than three percent (3%) of the non-HCV component of the TCOC Benchmark, Contractor's additional Shared Losses payment for the amount of Losses beyond three percent (3%) of the Non-HCV component of the TCOC Benchmark shall be equal to:
In Contract Years 1-3, additional Shared Losses shall be ten percent (10%) of such additional Losses; and
In Contract Years 4-5, additional Shared Losses shall be fifteen percent (15%) of such additional Losses;

Risk Track 2 – Moderate Accountability

If Contractor selects Risk Track 2 – Moderate Accountability, then subject to the provisions in **Section 2.7.D.2.a** above, Contractor's Shared Savings payment or Shared Losses payment, prior to modifying for Contractor's Quality Score as described in **Section 2.7.E** below, shall be as follows:

If Contractor has Savings less than or equal to three percent (3%) of the Non-HCV component of the TCOC Benchmark:
In Contract Year 1, Shared Savings shall be thirty percent (30%) of Savings;
In Contract Year 2, Shared Savings shall be forty percent (40%) of Savings;
In Contract Years 3-5, Shared Savings shall be fifty percent (50%) of Savings;

If Contractor has Savings greater than three percent (3%) of the Non-HCV component of the TCOC Benchmark, Contractor's additional Shared Savings payment for the amount of Savings above three percent (3%) of the Non-HCV component of the TCOC Benchmark shall be equal to:
In Contract Year 1, additional Shared Savings shall be fifteen percent (15%) of such additional Savings;
In Contract Year 2, additional Shared Savings shall be twenty percent (20%) of such additional Savings;
In Contract Years 3-5, additional Shared Savings shall be twenty-five percent (25%) of such additional Savings;

If Contractor has Losses with absolute value less than or equal to three percent (3%) of the Non-HCV component of the TCOC Benchmark:
In Contract Years 1-3, Shared Losses shall be thirty percent (30%) of Losses; and
In Contract Years 4-5, Shared Losses shall be fifty percent (50%) of Losses;

If Contractor has Losses with absolute value greater than three percent (3%) of the Non-HCV component of the TCOC Benchmark, Contractor's additional Shared Losses payment for the amount of Losses beyond three percent (3%) of the Non-HCV component of the TCOC Benchmark shall be equal to:

In Contract Years 1-3, additional Shared Losses shall be fifteen percent (15%) of such additional Losses; and

In Contract Years 4-5, additional Shared Losses shall be twenty-five percent (25%) of such additional Losses;

Risk Track 3 – Increased Accountability

If Contractor selects Risk Track 3 – Increased Accountability, then subject to the provisions in **Section 2.7.D.2.a** above, Contractor's Shared Savings payment or Shared Losses payment, prior to modifying for Contractor's Quality Score as described in **Section 2.7.E** below, shall be as follows:

If Contractor has Savings less than or equal to three percent (3%) of the Non-HCV component of the TCOC Benchmark:

In Contract Year 1, Shared Savings shall be fifty percent (50%) of Savings;

In Contract Year 2, Shared Savings shall be sixty percent (60%) of Savings; and

In Contract Years 3-5, Shared Savings shall be seventy percent (70%) of Savings;

If Contractor has Savings greater than three percent (3%) of the Non-HCV component of the TCOC Benchmark, Contractor's additional Shared Savings payment for the amount of Savings above three percent (3%) of the Non-HCV component of the TCOC Benchmark shall be equal to:

In Contract Year 1, additional Shared Savings shall be twenty-five percent (25%) of such additional Savings;

In Contract Year 2, additional Shared Savings shall be thirty percent (30%) of such additional Savings;

In Contract Years 3-5, additional Shared Savings shall be thirty-five percent (35%) of such additional Savings;

If Contractor has Losses with absolute value less than or equal to three percent (3%) of the Non-HCV component of the TCOC Benchmark:

In Contract Years 1-3, Shared Losses shall be forty percent (40%) of Losses; and

In Contract Years 4-5, Shared Losses shall be seventy percent (70%) of Losses;

If Contractor has Losses with absolute value greater than three percent (3%) of the Non-HCV component of the TCOC Benchmark, Contractor's additional Shared Losses payment for the amount of Losses beyond three percent (3%) of the Non-HCV component of the TCOC Benchmark shall be equal to:

In Contract Years 1-3, additional Shared Losses shall be twenty percent (20%) of such additional Losses; and

In Contract Years 4-5, additional Shared Losses shall be thirty-five percent (35%) of such additional Losses;

Risk Sharing for the HCV Component of the TCOC Benchmark

If the Contractor has Savings less than or equal to five percent (5%) of the HCV component of the TCOC Benchmark, the Contractor's Shared Savings shall be one hundred percent (100%) of the Savings;

If the Contractor has Savings greater than five percent (5%) of the HCV component of the TCOC Benchmark, Contractor's additional Shared Savings payment for the amount of Savings above five percent (5%) of the HCV component of the TCOC Benchmark shall be five percent (5%) of such additional Savings;

If the Contractor has Losses with absolute value less than or equal to five percent (5%) of the HCV component of the TCOC Benchmark, the Contractor's Shared Losses shall be one hundred percent (100%) of the Losses;

If the Contractor has Losses with absolute value greater than five percent (5%) of the HCV component of the TCOC Benchmark, Contractor's additional Shared Losses payment for the amount of Losses beyond five percent (5%) of the HCV component of the TCOC Benchmark shall be five percent (5%) of such additional Losses; and

The Savings and Losses cap shall be equal to 10% of the HCV component of the TCOC Benchmark (hereinafter referred to as "the HCV cap"). If the Contractor's Savings for the HCV component of the TCOC Benchmark are greater than the HCV cap, the Contractor's Shared Savings payment shall be calculated as if the Contractor's Savings were equal to the HCV cap, and the Contractor shall receive no additional Shared Savings payment for any Savings beyond the HCV cap. If the absolute value of the Contractor's Losses for the HCV component of the TCOC Benchmark are greater than the HCV cap, the Contractor's Shared Losses payment shall be calculated as if the absolute value of the Contractor's Losses were equal to the HCV cap, and the Contractor shall make no additional Shared Losses payment for any Losses beyond the HCV cap.

Risk Sharing for Selected RC II Adult Regions specified under the Contractor's Chosen RC II Adult Risk Sharing Arrangement for Contract Year 1

The Contractor's Shared Savings payment or Shared Losses payment for the non-HCV component of the TCOC Benchmark for Selected RCII Adult Regions, prior to modifying for the Contractor's Quality Score as described in **Section 2.7.E** below shall be as follows:
If the Contractor has Savings less than or equal to one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions, as defined in **Section 2.7.E.2.g.**, the Contractor's Shared Savings shall be twenty percent (20%) of the Savings if the Contractor elects "Risk Track 1 – Limited Accountability"; thirty percent (30%) of the Savings if the Contractor elects "Risk Track 2 – Moderate

Accountability"; and fifty percent (50%) of the Savings if the Contractor elects "Risk Track 3 – Increased Accountability";

If the Contractor has Savings greater than one percent (1%) and less than or equal to two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions, as defined in **Section 2.7.E.2.g**;

the Contractor's Shared Savings payment for the amount of Savings below one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be twenty percent (20%) of the Savings if the Contractor elects "Risk Track 1 – Limited Accountability"; thirty percent (30%) of the Savings if the Contractor elects "Risk Track 2 – Moderate Accountability"; and fifty percent (50%) of the Savings if the Contractor elects "Risk Track 3 – Increased Accountability;" and

the Contractor's Shared Savings payment for the amount of Savings above 1% of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be ten percent (10%) of the Savings if the Contractor elects "Risk Track 1 – Limited Accountability"; fifteen percent (15%) of the Savings if the Contractor elects "Risk Track 2 – Moderate Accountability"; and twenty-five percent (25%) of the Savings if the Contractor elects "Risk Track 3 – Increased Accountability;"

If the Contractor has Savings greater than 2% of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions, as defined **in Section 2.7.E.2.g**;

the Contractor's Shared Savings payment for the amount of Savings below one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be twenty percent (20%) of the Savings if the Contractor elects "Risk Track 1 – Limited Accountability"; thirty percent (30%) of the Savings if the Contractor elects "Risk Track 2 – Moderate Accountability"; and fifty percent (50%) of the Savings if the Contractor elects "Risk Track 3 – Increased Accountability";

the Contractor's Shared Savings payment for the amount of Savings between one percent (1%) and two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be ten percent (10%) of the Savings if the Contractor elects "Risk Track 1 – Limited Accountability"; fifteen percent (15%) of the Savings if the Contractor elects "Risk Track 2 – Moderate Accountability"; and twenty-five percent (25%) of the Savings if the Contractor elects "Risk Track 3 – Increased Accountability;" and

the Contractor's Shared Savings payment for the amount of Savings in excess of two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be 10% of the Savings;

If the Contractor has Losses less than or equal to one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions, as defined in **Section 2.7.E.2.g**., the Contractor's Shared Losses shall be twenty percent (20%) of the Losses if the Contractor elects "Risk Track 1 – Limited Accountability"; thirty percent (30%) of the Losses if the Contractor elects "Risk Track 2 – Moderate Accountability"; and forty percent (40%) of the Losses if the Contractor elects "Risk Track 3 – Increased Accountability";

If the Contractor has Losses greater than one percent (1%) and less than or equal to two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions, as defined in **Section 2.7.E.2.g**;

the Contractor's Shared Losses payment for the amount of Losses below one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be twenty percent (20%) of the Losses if the Contractor elects "Risk Track 1 – Limited Accountability"; thirty percent (30%) of the Losses if the Contractor elects "Risk Track 2 – Moderate Accountability"; and forty percent (40%) of the Losses if the Contractor elects "Risk Track 3 – Increased Accountability"; and

the Contractor's Shared Losses payment for the amount of Losses above one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be ten percent (10%) of the Losses if the Contractor elects "Risk Track 1 – Limited Accountability"; fifteen percent (15%) of the Losses if the Contractor elects "Risk Track 2 – Moderate Accountability"; and twenty percent (20%) of the Losses if the Contractor elects "Risk Track 3 – Increased Accountability";

If the Contractor has Losses greater than two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions, as defined in **Section 2.7.E.2.g**;

the Contractor's Shared Losses payment for the amount of Losses below one percent (1%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be twenty percent (20%) of the Losses if the Contractor elects "Risk Track 1 – Limited Accountability"; thirty percent (30%) of the Losses if the Contractor elects "Risk Track 2 – Moderate Accountability"; and forty percent (40%) of the Losses if the Contractor elects "Risk Track 3 – Increased Accountability";

the Contractor's Shared Losses payment for the amount of Losses between one percent (1%) and two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be ten percent (10%) of the Losses if the Contractor elects "Risk Track 1 – Limited Accountability"; fifteen percent (15%) of the Losses if the Contractor elects "Risk Track 2 – Moderate Accountability"; and twenty percent (20%) of the Losses if the Contractor elects "Risk Track 3 – Increased Accountability"; and

the Contractor's Shared Losses payment for the amount of Losses in excess of two percent (2%) of the non-HCV component of the TCOC Benchmark for Selected RC II Adult Regions shall be 10% of the Losses;

The savings and losses cap shall be equal to 10% of the non-HCV component of the TCOC Benchmark for Selected RCII Adult Regions (hereinafter "the RCII Adult cap"). If the Contractor's Savings for the non-HCV Component of the TCOC Benchmark for Selected RCII Adult Regions are greater than the RCII Adult cap, the Contractor's Shared Savings payment shall be calculated as if the Contractor's Savings were equal to the RCII Adult cap, and the Contractor shall receive no additional Shared Savings payment for any Savings beyond the RCII Adult cap. If the absolute value of the Contractor's Losses for the non-HCV Component of the TCOC Benchmark for Selected RCII Adult Regions are greater than the RCII Adult cap, the Contractor's Shared Losses payment shall be calculated as if the absolute value of the Contractor's Losses were equal to the RCII Adult cap, and the Contractor shall make no additional Shared Losses payment for any Losses beyond the RCII Adult cap.

If EOHHS modifies the Risk Tracks, the Contractor agrees to negotiate in good faith to implement such modifications, and to negotiate in good faith with any Contracting MCOs to implement any such modifications in the Contractor's Approved ACO Agreement.

Quality Modifier and Payment

Prior to payment, the Contractor's combined Shared Savings or Shared Losses payment for the Non-HCV and Selected RC II Adult Regions components of the TCOC Benchmark calculated in **Sections 2.7.B and 2.7.C** shall be adjusted based on Contractor's Quality Score, and the Contracting MCO or Contractor shall pay the resulting adjusted amount, as follows:

The Contractor's Quality Score shall be calculated as described in **Appendix B**. Contractor's Quality Score shall be a number between zero (0) and one (1) as determined by EOHHS;

If the Contractor has combined Shared Savings for the Non-HCV and Selected RC II Adult Regions components of the TCOC Benchmark as calculated in **Sections 2.7.A and 2.7.B** above, the amount of such Shared Savings shall be multiplied by Contractor's Quality Score. The resulting amount shall be the amount of Contractor's Shared Savings payment for the Contract Year, and the Contracting MCO shall pay Contractor such resulting amount;

If the Contractor has combined Shared Losses for the Non-HCV and Selected RC II Adult Regions components of the TCOC Benchmark, eighty percent (80%) of such Shared Losses shall be unmodified by Contractor's Quality Score. The remaining twenty percent (20%) of Contractor's Shared Losses payment shall be multiplied by an amount equal to one (1) minus the Contractor's Quality Score. Such product, plus the unmodified eighty percent (80%) of Contractor's initial Shared Losses, shall be the amount of Contractor's Shared Losses payment for the Contract Year, and Contractor shall pay the Contracting MCO such resulting amount;

The Contracting MCO shall pay Contractor the Shared Savings payment, as adjusted for Contractor's Quality Score in this Section, or notify Contractor of Contractor's Shared Losses payment for each Contract Year no later than one calendar year from the end of the Contract Year; and

The Contractor shall pay the Contracting MCO any Shared Losses payment, as adjusted for Contractor's Quality Score as set forth in this Section, within thirty (30) days of receiving such notification from the Contracting MCO of the amount of the Contractor's Shared Losses payment.

TCOC Benchmark and TCOC Performance Calculations

The Contractor's TCOC for a given period shall be calculated as follows and as further specified by EOHHS:

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

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

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

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

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

The Contractor's TCOC Benchmark shall be calculated each Contract Year according to EOHHS specifications as follows:

The Contractor's Historic TCOC and Contractor's Market-Rate TCOC shall be calculated as described in this Section;

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

The Contractor's Historic TCOC shall be calculated as follows:
The Contractor's TCOC shall be calculated during a baseline period, as further specified by EOHHS;
Such TCOC shall be adjusted to account for anticipated trend between the baseline period and the Contract Year, and to account for the anticipated impact of changes to the MassHealth program to ensure that Contractor is not unfairly penalized or rewarded for such program changes, as further specified by EOHHS;
Such adjusted TCOC shall be Contractor's Historic TCOC.

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

Base rates for each EOHHS rating category shall be calculated based on the costs of care for all ACO-Eligible Members in each such rating category during a baseline period, as further specified by EOHHS, and using similar adjustments and exclusions as described above for TCOC calculations;
EOHHS will risk adjust such base rates as further specified by EOHHS using a generally accepted diagnosis grouper and statistically developed risk model. Such risk model may include adjustments for Attributed Members' health-related social needs;
These base rates shall be averaged across the Contractor's population of Attributed Members based on the number of Attributed Members the Contractor has in each rating category, as further specified by EOHHS;
The resulting amount shall be the Contractor's Market-Rate TCOC;

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

The Contractor's preliminary TCOC Benchmark for a Contract Year shall be calculated no later than one month prior to the start of the Contract Year;

The subcomponents of the Contractor's TCOC Benchmark shall be calculated as follows:
For Contract Year 1:
Non-HCV component, which will reflect all costs within the TCOC Benchmark less the cost of Attributed Members' HCV Drugs paid for by MassHealth and less costs relating to Attributed Members in Selected RC II Adult Regions;
HCV component, which will reflect the cost of Attributed Members' HCV Drugs paid for by MassHealth; and
Selected RC II Adult Regions component, which will reflect the non-HCV costs relating to Attributed Members in the Selected RC II Adult Regions.
For subsequent Contract Years:
Non-HCV component, which will reflect all costs within the TCOC Benchmark less the cost of Attributed Members' HCV Drugs paid for by the Contracting MCO; and
HCV component, which will reflect the cost of Attributed Members' HCV Drugs paid for by the Contracting MCO.

Additional retrospective adjustments to Contractor's TCOC Benchmark may be made to ensure the TCOC Benchmark is appropriate and to ensure Contractor is not unfairly penalized or rewarded, as further specified and approved by EOHHS. Such adjustments may include but may not be limited to adjustments such as:
Additional program changes not initially captured;
Modifications to trend based on unforeseen events;
Adjustments to reflect updated accounting of the number of Attributed Members in each rating category.

The Contractor's TCOC Performance shall be calculated by calculating Contractor's TCOC during the Contract Year.

EOHHS shall publish the detailed methodology for calculating TCOC Benchmark and TCOC Performance, including details such as the definition of the baseline year and the terms and conditions for any retrospective adjustments to the Contractor's TCOC Benchmark, prior to the Operational Start Date, and shall publish any subsequent revisions no later than thirty (30) days prior to the start of the Contract Year for which the methodology revisions take effect.

Community Partners Requirements

At all times after the Community Partners Operational Start Date, the Contractor shall maintain agreements with Community Partners, as set forth in this **Section 2.8**.

Behavioral Health Community Partners (BH CPs)

The Contractor shall maintain ACO/MCO – BH CP Agreements with all BH CPs within each geographic area served by the Contractor, in EOHHS' determination as follows and as further specified by EOHHS;

The Contractor shall not be required to maintain ACO/MCO-BH CP Agreements if so notified by EOHHS. Reasons for such notification may include the ACO having a limited number of Attributed Members over the age of 21 or other reasons specified by EOHHS; and

The Contractor shall not permit the Contractor's Material Subcontractor to enter into such ACO/MCO - BH CP Agreements on behalf of the Contractor.

With respect to BH CP-Identified Attributed Members, the Contractor shall work with the Contracting MCO, as further specified by EOHHS, to assign all BH CP-Identified Attributed Members to a BH CP as follows:

The Contractor shall work with the Contracting MCO to assign each BH CP-Identified Attributed Member to a BH CP within thirty (30) calendar days of being notified of such Attributed Member, provided however that:

Unless the Attributed Member is enrolled in DMH's Adult Community Clinical Services (ACCS), has transitioned out of ACCS, or transitioned out of DMH's Community Based Flexible Supports, or EOHHS has identified that the Attributed Member has an existing relationship with a BH CP, the Contractor may, but shall not be required to, assign BH CP-Identified Attributed Members under the circumstances set forth below; provided, however, that the Contractor shall ensure that such Attributed Members receive behavioral health coordination and management, as well as Care Management, as appropriate:

The Attributed Member is enrolled in hospice;

The Attributed Member is in a Chronic Disease and Rehabilitation Hospital at the time of identification; or

Other circumstances as further specified by EOHHS.

The Contractor shall report on such situations in a form and format to be specified by EOHHS.

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to assign each BH CP-Identified Attributed Member to the BH CP with which the Attributed Member has an existing relationship as determined by EOHHS, if applicable; and

The Contractor shall report to Contracting MCO which BH CP-Identified Attributed Members it has assigned to a BH CP and to which BH CP each such Attributed Member has been assigned in a form and format specified by EOHHS.

With respect to BH CP-Referred Attributed Members, the Contractor shall work with the Contracting MCO, as further specified by EOHHS, to:

As further specified by EOHHS, develop, implement, and maintain policies and procedures for:
Accepting and evaluation such referrals; and
Determining the appropriateness of assigning BH CP-Referred Attributed Members to a BH CP.

Accept and evaluate such referrals and determine whether it is appropriate to assign the BH CP - Referred Attributed Member to a BH CP, pursuant to the policies and procedures specified in **Section 2.8.A.3.a**;

Within thirty (30) calendar days of referral, assign BH CP-Referred Attributed Members determined appropriate for assignment to a BH CP, subject to availability, including the BH CP's capacity; and

As further specified by EOHHS, maintain documentation related to such referrals, including but not limited to information such as the name of the BH CP-Referred Attributed Member, name of the referrer, relation of the referrer to the BH CP-Referred Attributed Member, date of referral, status of referral, and BH CP to which the BH CP-Referred Attributed Members was assigned. The Contractor or the Contracting MCO, as further specified by EOHHS, shall provide such documentation to EOHHS upon request.

The Contractor shall work with the Contracting MCO to make best efforts to promptly begin coordinating with each BH CP with respect to the outreach, engagement, and care management of all

BH CP-Assigned Attributed Members assigned to that particular BH CP within seven (7) calendar days of the Contractor making such assignments. Such coordination shall include, but not be limited to:

Providing the BH CP with the name and contact information of such BH CP-Assigned Attributed Members;

Providing clinical, diagnostic, utilization, or cost information regarding the BH CP-Assigned Attributed Member to the BH CP;

Communicating by phone or in person to coordinate plans to outreach to and engage the BH CP-Assigned Attributed Member; and

Other forms of communication or coordination pursuant to the Contractor's ACO/MCO – CP Agreement with each BH CP.

The Contractor shall work with the Contracting MCO, as further specified by EOHHS, to accommodate requests from BH CP-Assigned or BH CP-Engaged Attributed Members to switch CPs, as follows:

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to develop and maintain policies and procedures for receiving, evaluating, and making determinations regarding such requests. Such policies and procedures shall account for BH CP-Assigned and BH CP-Engaged Attributed Member's preferences;

Within thirty (30) calendar days of receiving such request from BH CP-Assigned and BH CP-Engaged Attributed Members, the Contractor shall make best efforts to accommodate such requests and reassign pursuant to the policies and procedures specified in **Section 2.8.A.5.a**, subject to availability, including the CP's capacity;

The Contractor shall notify such Attributed Members of the Contractor's decision to reassign or not to reassign, as further specified by EOHHS;

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to maintain documentation related to such requests, including but not limited to information such as the name of the requesting BH CP-Assigned or BH CP-Engaged Attributed Member, the CP to which the BH CP-Assigned or BH CP-Engaged Attributed Member is assigned, the CP the BH CP-Assigned or BH CP-Engaged Attributed Member is requesting to switch to, if any, date of request and status of request. The Contractor or the Contracting MCO, as further specified by EOHHS, shall provide such documentation to EOHHS upon request; and

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to transfer care-related information about a BH CP-Assigned or Engaged Attributed Member to the BH CP to which such Attributed Member has been reassigned, including but not limited to the results of the Comprehensive Assessment and specified Care Plan information.

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to develop, implement, and maintain processes for:

Disengaging Attributed Members from a BH CP for reasons approved by EOHHS, including but not limited to when the Contractor, in consultation with the Attributed Member's BH CP and the Contracting MCO, determines that CP supports are no longer necessary, appropriate, or desired by the Attributed Member; and

Determining in consultation with the Contracting MCO when it is appropriate to transition responsibility for care coordination and care management from the BH CP to the Contractor for BH CP-Assigned or BH CP-Engaged Attributed Members who have certain medical complexities, as further specified by EOHHS;

Contractor shall designate appropriate administrative staff to satisfy the requirements of this **Section 2.8.A** and **Appendix G**, including at a minimum:

One (1) key contact from each of the Contractor and the ACO Partner, if applicable, responsible for regular communication with the Contractor's BH CPs about matters such as but not limited to data exchange, care coordination and care management. The Contractor shall provide its BH CPs with information about each such key contact, including, but not limited to the contact's name, title, organizational affiliation, and contact information. The Contractor shall provide its BH CPs with timely notification if such key contact changes; and

A Care Team Point of Contact responsible for conducting all ongoing communication with the Care Team; ensuring the BH CP is notified of and included in the BH CP-Engaged member's discharge planning and follow-up communication during transitions of care; and updating the BH CP about Medically Necessary specialty care to which an Attributed Member is referred or is receiving. The Contractor shall ensure that the Care Team Point of Contact has access to the Attributed Member's medical record and possesses the appropriate qualifications to read clinical notations.

The Contractor and the BH CP shall enter into and adhere to a written ACO/MCO – BH CP Agreement as follows:

Each such agreement between the Contractor and a BH CP shall, at a minimum, comply with the requirements of **Appendix G**;

Such agreement between the Contractor and a BH CP may delegate additional responsibilities under this Contract from the Contractor to the BH CP provided such responsibilities:
Are agreed upon by the BH CP;
Comply with the requirements of this Contract;
Are in the best interests of Attributed Members, and are intended to improve the coordination and Member-centeredness of care; and
Do not absolve the Contractor of any responsibility to EOHHS for the requirements of this Contract;"

Such agreement between the Contractor and a BH CP may not obligate the BH CP to accept downside financial risk in Contract Year 1 or Contract Year 2;

As further specified by EOHHS, the Contractor or the Contracting MCO, as further specified by EOHHS, shall report to EOHHS monthly, or at any other frequency specified by EOHHS, about the Contractor's BH CPs, including information such as but not limited to:

A list of BH CP-Identified Attributed Members, including whether each Attributed Member was assigned to a CP and the CP to which the Attributed Member was assigned;

A list of BH CP-Referred Attributed Members, including for each such Attributed Member whether the Attributed Member was assigned to a CP and the CP to which the Attributed Member was assigned; and

A list of BH CP-Assigned or BH CP-Engaged Attributed Members who requested to switch their BH CP, including for each such Attributed Member, the reason(s) for the requested switch, and the outcome of the request.

Long-Term Services and Supports Community Partners (LTSS CPs)

The Contractor shall maintain ACO/MCO – LTSS CP Agreements with at least two LTSS CPs within each geographic area served by the Contractor, in EOHHS' determination, as further specified by EOHHS. The Contractor shall not permit the Contractor's Material Subcontractor to enter into such ACO/MCO - LTSS CP Agreements on behalf of the Contractor.

With respect to LTSS CP-Identified Attributed Members, the Contractor shall work with the Contracting MCO, as further specified by EOHHS, to assign each LTSS CP-Identified Attributed Member to an LTSS CP as follows:

The Contractor shall assign each LTSS CP-Identified Attributed Member to an LTSS CP within thirty (30) calendar days of being notified of such Attributed Member; and

The Contractor shall report to the Contracting MCO which LTSS CP-Identified Attributed Members it has assigned to an LTSS CP and to which LTSS CP each such Attributed Member has been assigned.

With respect to LTSS CP-Referred Attributed Member, the Contractor shall work with the Contracting MCO, as further specified by EOHHS, to:

As further specified by EOHHS, develop, implement, and maintain policies and procedures for:
Accepting and evaluating such referrals; and
Determining the appropriateness of assigning LTSS CP-Referred Attributed Members to an LTSS CP;

Accept and evaluate such referrals and determine whether it is appropriate to assign the LTSS CP-Referred Attributed Member to an LTSS CP, pursuant to the policies and procedures specified in **Section 2.8.B.3.a**;

Within thirty (30) calendar days of referral; assign LTSS CP-Referred Attributed Members determined appropriate for assignment to an LTSS CP, subject to availability, including the LTSS CP's capacity; and

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to maintain documentation related to such referrals, including but not limited to information such as name of the LTSS CP-Referred Attributed Member, name of the referrer, relation of the referrer to the LTSS CP-Referred Attributed Member, date of referral, status of referral, and LTSS CP to which the LTSS CP-Referred Attributed Member was assigned. The Contractor or the Contracting MCO, as further specified by EOHHS, shall provide such documentation to EOHHS upon request.

The Contractor shall work with the Contracting MCO to make best efforts to promptly begin coordinating with each LTSS CP with respect to the outreach, engagement, and LTSS care coordination of all LTSS CP-Assigned Attributed Members assigned to that particular LTSS CP within seven (7) calendar days of the Contractor making such assignments. Such LTSS care coordination shall include, but not be limited to:

Providing the LTSS CP with the name and contact information for such LTSS CP-Assigned Attributed Members;

Providing necessary and appropriate information regarding the LTSS CP-Assigned Attributed Member to assist the LTSS CP in outreach and engagement;

Communicating by phone or in person with the LTSS CP to coordinate plans to outreach to and engage the LTSS CP-Assigned Attributed Member; and

Other forms of communication or coordination pursuant to the Contractor's ACO/MCO-CP Agreement with each LTSS CP.

The Contractor shall work with the Contracting MCO, as further specified by EOHHS, to accommodate requests from LTSS CP-Assigned or LTSS CP-Engaged Attributed Members to switch CPs, as follows:

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to develop and maintain policies and procedures for receiving, evaluating, and making determinations regarding such requests. Such policies and procedures shall account for LTSS CP-Assigned and LTSS CP-Engaged Attributed Members' preferences;

Within thirty (30) calendar days of such request from LTSS CP-Assigned an LTSS CP-Engaged Attributed Members, the Contractor shall work with the Contracting MCO to ensure best efforts are made to accommodate such requests and reassign pursuant to the policies and procedures specified in **Section 2.8.B.5.a**, subject to availability, including the CP's capacity;

The Contractor shall notify such Attributed Members of the Contractor's decision to reassign or not to reassign, as further specified by EOHHS; and

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to maintain documentation related to such requests, including but not limited to information such as the name of the requesting LTSS CP-Assigned or LTSS CP-Engaged Attributed Member, the CP to which the LTSS CP-Assigned or LTSS CP-Engaged Attributed Member is assigned, the CP the LTSS CP-Assigned or LTSS CP-Engaged Attributed Member is requesting to change to, if any, date of request and status of request. The Contractor or the Contracting MCO, as further specified by EOHHS, shall provide such documentation to EOHHS upon request; and

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to provide care-related information about a LTSS CP-Assigned or Engaged Attributed Member to the LTSS CP to which such Attributed Member has been reassigned, including but not limited to the results of the Comprehensive Assessment and specified Care Plan information.

As further specified by EOHHS, the Contractor shall work with the Contracting MCO to develop, implement, and maintain processes for disengaging Attributed Members from an LTSS CP for reasons approved by EOHHS, including but not limited to when the Contractor, in consultation with the Contracting MCO and the Attributed Member's LTSS CP, determines that CP supports are no longer necessary, appropriate, or desired by the Attributed Member.

The Contractor shall designate appropriate administrative staff to satisfy the requirements of **Section 2.8.B** and **Appendix H**, including at a minimum one (1) key contact responsible for regular communication with the Contractor's LTSS CPs about matters such as but not limited to data exchange, care coordination, and care management. The Contractor shall provide its LTSS CPs with information about such key contact, including but not limited to the contact's name, title, organizational affiliation, and contact information. The Contractor shall provide its LTSS CPs with timely notification if such key contact changes.

The Contractor and the LTSS CP shall enter into and adhere to a written ACO/MCO – LTSS CP Agreement as follows:

Each such agreement between the Contractor and a LTSS CP shall at a minimum comply with the requirements of **Appendix H**.

Such agreement between the Contractor and a LTSS CP may delegate additional responsibilities under this Contract from the Contractor to the LTSS CP provided such responsibilities:

Are agreed upon by the LTSS CP;
Comply with the requirements of this Contract;
Are in the best interests of Attributed Member, and are intended to improve the coordination and Member-centeredness of care; and
Do not absolve the Contractor of any responsibility to EOHHS for the requirements of this Contract.

Such agreement between the Contractor and an LTSS CP may not obligate the LTSS CP to accept downside financial risk in Contract Year 1 or Contract Year 2;

Such agreement between the Contractor and a LTSS CP may not obligate the LTSS CP to accept downside financial risk in Contract Year 1 or Contract Year 2; and

As further specified by EOHHS, the Contractor shall report to EOHHS monthly, or at any other frequency specified by EOHHS, about the LTSS CPs, including but not limited to:

A list of LTSS CP-Identified Attributed Members, including whether each Attributed Member was assigned to a CP and, the CP to which the Attributed Member was assigned;

A list of LTSS CP-Referred Attributed Members, including whether each Attributed Member was assigned to a CP and, the CP to which the Attributed Member was assigned; and

A list of LTSS CP-Assigned or LTSS CP-Engaged Attributed Members who requested to switch their CP including for each such Attributed Member the reasons for the requested switch and the outcome of the request.

Marketing and Communication

General Requirements

In conducting any Marketing activities described herein, the Contractor shall:

Ensure that all Marketing Materials clearly state that information regarding all MassHealth managed care enrollment options including, but not limited to, any Contracting MCOs, are available from the MassHealth Customer Service Center. The Contractor shall ensure that all written Marketing Materials prominently display the telephone number and hours of operation of the MassHealth Customer Service Center in the same font size as the same information for the Contractor's customer service center, if any. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by the Contractor;

Submit all Marketing Materials to EOHHS for approval prior to distribution. The Contractor shall submit Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible;

Distribute and/or publish Marketing Materials in a non-targeted manner, as further specified by EOHHS, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials (1) to a part of the Contractor's service area as defined by EOHHS; or (2) where the campaign relates to a local event (such as a health fair) or to a single provider (such as a hospital or clinic), to a certain zip code or zip codes; and

Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval;

Permissible Marketing Activities

The Contractor may only engage in the following Marketing activities.

A health fair or community activity, as further directed by EOHHS. The Contractor may conduct or participate in Marketing at health fairs and other community activities only if:

Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to be attributed to the Contractor;

The Contractor may participate in health benefit fairs sponsored by EOHHS, as further specified by EOHHS;

The Contractor may market to Members in accordance with **Section 2.6.A** by distributing and/or publishing Marketing Materials in a non-targeted manner or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

Posting written Marketing Materials that have been pre-approved by EOHHS at provider sites and other locations; and posting written promotional Marketing Materials at MCO-network provider and other sites as specified by EOHHS;

Initiating mailing campaigns that have been pre-approved by EOHHS, where the Contractor distributes Marketing Materials by mail; and

Television, radio, newspaper, website postings, and other audio or visual advertising.

Prohibitions on Marketing and Enrollment Activities

The Contractor shall not:

Distribute any Marketing Material that has not been pre-approved by EOHHS;

Distribute any Marketing Material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the Marketing Material, including but not limited to, any assertion or statement, whether written or oral, that:

The recipient of the Marketing Material must enroll with the Contractor in order to obtain benefits or in order to not lose benefits;

The Contractor is endorsed by CMS, the federal or state government or similar entity;

Seek to influence a Member's enrollment in conjunction with the sale or offering of any private or non-health insurance products (e.g., life insurance);

Seek to influence a Member's enrollment in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts;

Directly or indirectly, engage in door-to-door, telephonic, or any other Cold-call Marketing activities;

Engage in any Marketing activities which could mislead, confuse or defraud Attributed Members, or misrepresent MassHealth, EOHHS, the Contractor, or CMS;

Conduct any provider-site Marketing, except as approved by EOHHS; or

Engage in Marketing 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.

Marketing Plan and Schedules

The Contractor shall make available to EOHHS, upon request, for review and approval:

A comprehensive Marketing plan including proposed Marketing approaches to groups and individuals; and

Current schedules of all Marketing activities, including the methods, modes, and media through which Marketing Materials will be distributed.

Annually, the Contractor shall present its Marketing plan in person to EOHHS for review and approval.

Annually, the Contractor shall submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its Marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud Members or the state.

Information to Attributed Members

Nothing herein shall be deemed to prohibit the Contractor from providing non-Marketing information to Attributed Members consistent with this Contract, regarding new services, personnel, Attributed Member education materials, Care Management programs, advantages of being enrolled with the Contractor, and provider sites.

Contractor Website

The Contractor shall develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Attributed Members and providers to quickly and easily locate all relevant information, as specified by EOHHS. If directed by EOHHS, the Contractor shall establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal;

MassHealth Benefit Request and Eligibility Redetermination Assistance

The Contractor or provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:

Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants;

Assist MassHealth applicants in completing and submitting MBRs;

Offer to assist applicants with completion of the annual ERV form; and

Refer MassHealth applicants to the Exchange and MassHealth Customer Service Center.

EOHHS RESPONSIBILITIES

CONTRACT MANAGEMENT

EOHHS shall:

A. Provide certain documents, data, reports, materials and other information to assist the Contractor in performing under the Contract;

B. Pay Contractor in accordance with **Section 4.2**;

C. Evaluate reports and materials submitted by Contractor for approval as specified in this contract, including but not limited to Contractor's DSRIP Participation Plan, Contractor's Budgets and Budget Narratives, and Contractor's Progress Reports; and

D. Designate an individual authorized to represent EOHHS regarding all aspects of the Contract. EOHHS' representative shall act as a liaison between the Contractor and EOHHS during the Contract Term. The representative shall be responsible for:

MONITORING COMPLIANCE WITH THE TERMS OF THE CONTRACT;

RECEIVING AND RESPONDING TO ALL INQUIRIES AND REQUESTS MADE BY THE CONTRACTOR UNDER THIS CONTRACT;

MEETING WITH THE CONTRACTOR'S REPRESENTATIVE ON A PERIODIC OR AS-NEEDED BASIS FOR PURPOSES INCLUDING BUT NOT LIMITED TO DISCUSSING ISSUES WHICH ARISE UNDER THE CONTRACT; AND

COORDINATING WITH THE CONTRACTOR, AS APPROPRIATE, ON CONTRACTOR REQUESTS FOR EOHHS STAFF TO PROVIDE ASSISTANCE OR COORDINATION ON CONTRACTOR RESPONSIBILITIES.

QUALITY MEASUREMENT

EOHHS shall assist the Contractor and Contracting MCOs with assessing the Contractor's performance on Quality Measures, including activities such as:

A. Administering the Patient Experience Survey. Such survey may include, but shall not be limited to, questions about the Attributed Member's experience of care from their Participating PCP. EOHHS may modify the Patient Experience Survey in EOHHS' sole discretion;

B. Providing the Contractor with the Quality Sample for each Clinical Quality Measure within the final sixty (60) days of each Contract Year, or at another time specified by EOHHS; and

C. Calculating the total Quality Score for the Contractor.

Enrollment and Attribution

A. EOHHS shall inform Eligible Members of their enrollment options in an unbiased manner, including the option of becoming Attributed Members for the Contractor or another ACO in the MassHealth ACO program, and shall inform each Member at the time of enrollment of their right to change enrollment without cause within 90 days and at other times in accordance with applicable rules and regulations; and

B. EOHHS may assign certain Members that fail to make a selection to a Contracting MCO, including but not limited to if the Member has an existing relationship with one of the Contractor's Participating PCPs in EOHHS' determination. The Contracting MCO may assign such Members to the Contractor's PCPs at the Contracting MCO's discretion.

Call Center and Member Protections

A. EOHHS shall provide a Customer Service Center for use by Attributed Members.

B. EOHHS shall provide Appeals and Ombudsman processes to Attributed Members.

Community Partner Certification

EOHHS shall certify Community Partners and notify Contractor of available certified Community Partners.

Participating PCP Modification Process

EOHHS shall maintain, and may update from time to time, an annual process for the Contractor to request EOHHS' approval for changes to the Contractor's list of Participating PCPs, including ending affiliations with Participating PCPs and adding new Participating PCPs. Such changes shall in all cases be subject to EOHHS' approval. The Contractor shall submit requests for any such changes pursuant to EOHHS' defined process, including timelines, and the effective date of any such changes shall be as described by EOHHS' defined process.

DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)

CONTRACTOR RESPONSIBILITIES AND REPORTING REQUIREMENTS UNDER DSRIP

DSRIP PARTICIPATION PLAN

The Contractor shall at all times during the Contract Term maintain an EOHHS-approved DSRIP Participation Plan in a form and format specified by EOHHS and as described in this Section.

THE CONTRACTOR'S PRELIMINARY PARTICIPATION PLAN AS APPROVED BY EOHHS SHALL SATISFY THIS REQUIREMENT UNTIL THE START OF PERFORMANCE YEAR 1 OR AS OTHERWISE DEFINED BY EOHHS.

THE CONTRACTOR'S DSRIP PLAN SHALL BE IN A FORM AND FORMAT SPECIFIED BY EOHHS AND SHALL PROVIDE, AT A MINIMUM, THE FOLLOWING INFORMATION:

THE CONTRACTOR'S 5-YEAR BUSINESS PLAN, INCLUDING CONTRACTOR'S GOALS AND IDENTIFIED CHALLENGES UNDER THIS CONTRACT;

THE PROVIDERS AND ORGANIZATIONS (INCLUDING BUT NOT LIMITED TO AFFILIATED PROVIDERS) WITH WHICH CONTRACTOR IS PARTNERING OR PLANS TO PARTNER FOR THE PURPOSES OF THIS CONTRACT, INCLUDING DESCRIPTIONS OF HOW THESE PARTNERSHIPS WILL SUPPORT CONTRACTOR'S PLANNED ACTIVITIES AND PROPOSED INVESTMENTS UNDER THIS CONTRACT;

A POPULATION AND COMMUNITY NEEDS ASSESSMENT, INCLUDING:
THE POPULATION OF ATTRIBUTED MEMBERS THE CONTRACTOR SERVES AND THE COMMUNITIES IN WHICH THEY LIVE;
THE HEALTH AND FUNCTIONAL NEEDS OF SUCH POPULATION AND COMMUNITIES;
HOW THE CONTRACTOR'S PLANNED ACTIVITIES AND PROPOSED INVESTMENTS WILL PROMOTE THE HEALTH AND WELLBEING OF ATTRIBUTED MEMBERS;
HOW THE CONTRACTOR PLANS TO ENGAGE ATTRIBUTED MEMBERS AND THEIR COMMUNITIES; AND
THE COMMUNITY RESOURCES THAT CURRENTLY EXIST FOR ATTRIBUTED MEMBERS, AND HOW THE CONTRACTOR IS PARTNERING OR PLANS TO PARTNER WITH SUCH RESOURCES FOR THE PURPOSES OF THIS CONTRACT;

AS FURTHER SPECIFIED BY EOHHS, THE CONTRACTOR'S PLANNED INVESTMENTS AND SPENDING PLAN, INCLUDING:
SPECIFIC INVESTMENTS OR PROGRAMS CONTRACTOR WILL SUPPORT WITH DSRIP FUNDS. SUCH INVESTMENTS AND PROGRAMS MAY INCLUDE BUT ARE NOT LIMITED TO:
CARE COORDINATION OR CARE MANAGEMENT PROGRAMS, INCLUDING ANY PROGRAMS TO MANAGE HIGH-RISK POPULATIONS OR OTHER POPULATION HEALTH INITIATIVES AND INCLUDING CONTRACTOR'S TRANSITIONAL CARE MANAGEMENT PROGRAM AS DESCRIBED IN SECTION 2.5.C.2;
EFFORTS TO ADDRESS ATTRIBUTED MEMBERS' HEALTH-RELATED SOCIAL NEEDS, INCLUDING EXPANDING COMMUNITY LINKAGES BETWEEN CONTRACTOR AND PROVIDERS, CPS, OR OTHER SOCIAL SERVICE ORGANIZATIONS, AND INCLUDING ANY SPENDING ON ALLOWABLE FLEXIBLE SERVICES TO ADDRESS HEALTH-RELATED SOCIAL NEEDS;
ENSURING APPROPRIATE WORKFORCE CAPACITY AND PROFESSIONAL DEVELOPMENT OPPORTUNITIES TO MEET INCREASED EXPECTATIONS FOR CARE COORDINATION, MANAGEMENT, AND INTEGRATION;

Investments in Contractor's and Affiliated Providers' data and analytics capabilities;
Programs to shift service volume or capital away from avoidable inpatient care towards outpatient, community based primary and preventative care, or from institutional towards community-based LTSS, including capital investments to downsize or re-purpose inpatient or institutional capacity, investments in expanding outpatient and community capacity, and costs associated with piloting new care delivery models, such as those involving alternate settings of care and the use of telehealth or home-based services;
Investments in cultural and linguistic accessibility of services, including hiring translators and providers fluent in Attributed Members' preferred languages, or in medical and diagnostic equipment that is accessible to members with disabilities; and
Other investments or programs identified and proposed by the Contractor that meet the other requirements of this Contract;
Estimates of the amount and structure (e.g., one-time vs. annual) of costs associated with each investment or program the Contractor identifies in its DSRIP Participation Plan;
Descriptions of how each such investment or program will support Contractor's performance of the requirements of this Contract and EOHHS' goals of improving the quality and efficiency of Attributed Members' care;
Specific goals, evaluation plans, measurable outcomes, and performance management strategies Contractor will apply to each investment or program to demonstrate effectiveness and inform subsequent revisions;
A 5-year timeline of Contractor's proposed investments and programs; and
A description of Contractor's plan to sustainably fund proposed investments and programs over the 5-year period as DSRIP funding levels decrease;

A description of how Contractor will fulfill the following requirements of this Contract:
The Contractor's planned investments, value-based payment arrangements, and performance management for Participating PCPs, as described in **Sections 2.2.A.2 and 2.2.A.3**;
The Contractor's activities related to Contractor's care delivery and Care Management responsibilities as described in **Sections 2.5**, including:
Contractor's Wellness Initiatives and Disease Management programs, as described in Section 2.5.A.2.i and Section 2.5.A.2.j;
Contractor's Care Needs Screening and Contractor's activities to support Attributed Members' access to appropriate care, as described in Section 2.5.B;
Contractor's Transitional Care Management program, as described in Section 2.5.C.2;
Contractor's coordination with Contracting MCOs with respect to the Contracting MCOs' Clinical Advice and Support Lines, as described in Section 2.5.C.3;
Contractor's approach to Comprehensive Assessments and care planning, as described in Section 2.5.D; and
Contractor's Care Management activities, as described in Section 2.5.E;

Contractor's relationships with Affiliated Providers, state agencies, and other entities involved in the care of Attributed Members;
Contractor's relationships with CPs specifically, including how Contractor and CPs coordinate care, resolve potential conflicts, and delineate responsibilities for care coordination and Care Management activities, as described in **Sections 2.8.A and 2.8.B**;
Contractor's activities to ensure Contractor's compliance with the contract management, reporting, and administrative requirements described in **Section 2.3**; and
The Contractor's activities pursuant to any other requirements of this Contract specified by EOHHS.

A plan to increase the Contractor's capabilities to share information among providers involved in Attributed Members' care. Such plan shall include, at a minimum:
The Contractor's current event notification capabilities and procedures to ensure that the Contractor's Participating PCPs are aware of Attributed Members' inpatient admissions and emergency department visits;
The Contractor's self-assessed gaps in such capabilities and procedures, and how the Contractor plans to address such gaps;
A description of the Contractor's plans, if any, to increase the use of EHR technologies certified by the Office of the National Coordinator (ONC); and
A description of how Contractor plans to ensure the Contractor's Affiliated Providers consistently use the HIway to send or receive legally and clinically appropriate patient clinical information and support transitions of care.

Attestations to ensure non-duplication of funding.

The Contractor shall submit its DSRIP Participation Plan to EOHHS for approval within 30 calendar days of EOHHS request, or as further specified by EOHHS;

The Contractor shall update and resubmit its DSRIP Participation Plan to EOHHS for approval upon any significant anticipated changes in the Contractor's future activities or investments under its DSRIP Participation Plan as follows, or as otherwise requested by EOHHS:

For any significant anticipated changes in the Contractor's future activities or investments identified by the Contractor, the Contractor shall update and resubmit its DSRIP Participation Plan to EOHHS for approval, provided however that the Contractor may not request modification to its DSRIP Participation Plan within 75 calendar days of the end of the current Performance Year;

For any significant anticipated changes in the Contractor's future activities or investments identified by EOHHS, including, but not limited to, such changes related to the approved addition of new Participating PCPs pursuant to **Section 2.2.A.4**, the Contractor shall submit its modified DSRIP Participation Plan to EOHHS for approval within 30 calendar days of EOHHS' request, or as further specified by EOHHS; and

The Contractor's DSRIP Participation Plan shall be subject to review and approval by EOHHS. EOHHS may withhold the Contractor's DSRIP payment until EOHHS approves the Contractor's DSRIP Participation Plan.

Budgets and Budget Narratives

The Contractor shall submit Budgets and Budget Narratives to EOHHS as follows:

The Budget and Budget Narrative shall be in form and format specified by EOHHS;

The Contractor shall submit the Budget and Budget Narrative annually for each Performance Year, or at another frequency specified by EOHHS and within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

The Contractor shall update and resubmit its Budget and Budget Narrative to EOHHS for approval upon any significant anticipated changes in the Contractor's future activities or investments under its Budget and Budget Narrative as follows, or as otherwise requested by EOHHS:

For any significant anticipated changes in the Contractor's future activities or investments identified by the Contractor, the Contractor shall update and resubmit its Budget and Budget Narrative to EOHHS for approval, provided however that the Contractor may not request modification to its Budget and Budget Narrative within 75 calendar days of the end of the current Performance Year;

For any significant anticipated changes in the Contractor's future activities or investments identified by EOHHS, the Contractor shall submit its modified Budget and Budget Narrative to EOHHS for approval within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

The Budget shall show how the Contractor proposes to spend DSRIP payments for the Performance Year, and the Budget Narrative shall describe how this spending will support Contractor's DSRIP Participation Plan and the Contractor's activities under this Contract; and

EOHHS may withhold the Contractor's DSRIP payment until EOHHS approves the Contractor's Budget and Budget Narrative for that Performance Year;

Progress Reports

The Contractor shall submit Progress Reports to EOHHS as follows:

The Progress Reports shall be in form and format specified by EOHHS;

The Contractor shall submit the Progress Reports semiannually, or at another frequency specified by EOHHS;

The Progress Reports shall describe the Contractor's activities under the Contractor's DSRIP Participation Plan and under this Contract, including challenges, successes, and requested modifications to the Participation Plan and other information, as further specified by EOHHS;

THE PROGRESS REPORTS SHALL INCLUDE A DESCRIPTION AND METRICS ON CONTRACTOR'S VALUE-BASED PAYMENTS FOR PARTICIPATING PCPS AS DESCRIBED IN **SECTION 2.2.A.2**, INCLUDING MEASURES SUCH AS THE PERCENT OF PARTICIPATING PCPS OPERATING UNDER A VALUE-BASED INCENTIVE, THE SIZE OF THE POTENTIAL GAIN OR LOSS FOR EACH PARTICIPATING PCP UNDER SUCH AN ARRANGEMENT, THE ACTUAL AMOUNT OF PERFORMANCE-BASED GAINS OR LOSSES REALIZED BY SUCH PARTICIPATING PCPS, AND THE RESULTS OF CONTRACTOR'S PERFORMANCE MEASUREMENT AND MANAGEMENT STRATEGY FOR PARTICIPATING PCPS;

THE PROGRESS REPORTS SHALL CONTAIN UPDATED FINANCIAL ACCOUNTINGS OF CONTRACTOR'S SPENDING OF DSRIP PAYMENTS;

THE PROGRESS REPORTS SHALL BE SUBJECT TO MODIFICATION AND APPROVAL BY EOHHS;

EOHHS MAY WITHHOLD THE CONTRACTOR'S DSRIP PAYMENT UNTIL EOHHS APPROVES THE CONTRACTOR'S TO-DATE PROGRESS REPORTS; AND

EOHHS MAY REDUCE THE CONTRACTOR'S FUTURE DSRIP PAYMENTS OR OTHERWISE RECOUP PAYMENT FROM THE CONTRACTOR IF, UPON REVIEW OF THE FINANCIAL ACCOUNTINGS CONTAINED IN SUCH PROGRESS REPORTS, EOHHS DETERMINES THAT CONTRACTOR HAS NOT SPENT ALL CONTRACTOR'S DSRIP

PAYMENTS IN ACCORDANCE WITH THE CONTRACTOR'S DSRIP PARTICIPATION PLAN OR WITH THE REQUIREMENTS OF THIS CONTRACT.

REPORTING ON TOTAL PATIENT SERVICE REVENUE PAYER MIX

The Contractor shall report to EOHHS on the Contractor's total patient service revenue payer mix, as described in **Section 4.2.A.3.b.1**, in form and format as further specified by EOHHS and as directed by EOHHS, annually or at a frequency specified by EOHHS.

REPORTING ON CONTRACTOR'S CPS

The Contractor shall report information to EOHHS, as requested and further specified by EOHHS, on the Contractor's CPs, including but not limited to the number of BH CP-Identified Attributed Members assigned by Contractor to each of Contractor's BH CPs for outreach and enrollment and the number of Attributed Members receiving any care coordination support or Care Management activities in which an LTSS CP is involved.

REQUIREMENTS FOR SPENDING CONTRACTORS DSRIP PAYMENTS

The Contractor shall ensure and demonstrate to EOHHS' satisfaction that the Contractor's DSRIP payments are spent as follows:

CONTRACTOR SHALL SPEND DSRIP PAYMENTS IN ACCORDANCE WITH CONTRACTOR'S EOHHS-APPROVED DSRIP PARTICIPATION PLAN, PROGRESS REPORTS, BUDGETS, AND BUDGET NARRATIVES;

CONTRACTOR SHALL PAY EACH PARTICIPATING SAFETY NET HOSPITAL THE FULL AMOUNT OF DSTI GLIDE PATH PAYMENTS CONTRACTOR RECEIVES FOR SUCH PARTICIPATING SAFETY NET HOSPITAL;

CONTRACTOR SHALL SPEND AN AMOUNT OF ITS STARTUP AND ONGOING DSRIP NOT LESS THAN THE AMOUNT SPECIFIED BY EOHHS ON INVESTMENTS IN PARTICIPATING PCPS, AS DESCRIBED IN **SECTION 2.2.A.3** AND AS APPROVED AND FURTHER DIRECTED BY EOHHS; AND

CONTRACTOR SHALL ENSURE THAT ANY REIMBURSEMENT CONTRACTOR REQUESTS FROM CONTRACTOR'S FLEXIBLE SERVICES ALLOTMENT AS DESCRIBED IN **SECTION 4.2.C** IS NOT DUPLICATIVE OF FUNDING AVAILABLE THROUGH OTHER PUBLICLY AVAILABLE PROGRAMS.

PAYMENTS UNDER DSRIP

Subject to other terms and conditions of the Contract, including but not limited to EOHHS' receipt of all necessary federal and state approvals, EOHHS shall pay Contractor three streams of DSRIP funding (Startup and Ongoing DSRIP payments, DSTI Glide Path DSRIP payments, and Flexible Services DSRIP payments), as follows.

CONTRACTOR STARTUP AND ONGOING DSRIP PAYMENTS

EOHHS shall pay Contractor Startup and Ongoing DSRIP payments as follows:

EOHHS shall specify an amount of each Performance Year's Startup and Ongoing DSRIP payments that Contractor must spend on primary care investment as described in **Section 2.2.A.3**;

Each Performance Year, EOHHS shall pay Contractor an amount of Startup and Ongoing DSRIP payment, as follows:

Each Performance Year's total Startup and Ongoing DSRIP payment shall equal Contractor's per-Attributed Member amount calculated by EOHHS as described in **Section 4.2.A.3** and as further specified by EOHHS, multiplied by Contractor's number of Attributed Members calculated by EOHHS as described in **Section 4.2.A.5**, and as further specified by EOHHS;

EOHHS shall make such payments each Performance Year in four equal quarterly installments (two equal quarterly installments in Performance Year 0), or at another frequency and in other divisions specified by EOHHS;

A portion of this total payment shall be withheld (and quarterly payments reduced accordingly) until the following Performance Year, as follows:
The withheld amount shall be a percentage of the Contractor's remaining Startup and Ongoing DSRIP that is not specified for spending on primary care investment as described in **Section 4.1.F.3**. The percentages shall be as follows:
0% in Performance Year 0;
5% in Performance Year 1;
15% in Performance Year 2;
30% in Performance Year 3;
40% in Performance Year 4; and
50% in Performance Year 5.

EOHHS shall multiply the withheld amount by Contractor's DSRIP Accountability Score each Performance Year, and pay the resulting amount by the end of the following Performance Year, or at a time specified by EOHHS;

EOHHS shall calculate the per-Attributed Member amount of such payments every Performance Year as follows:

EOHHS shall determine a base rate for each Performance Year that is applicable to all Attributed Members;

EOHHS shall increase that base rate as follows:
For all Attributed Members, EOHHS shall further increase the base rate by 40% of the base rate;
Except for in Performance Years 0 and 1, for Attributed Members attributed to a health center, as designated by EOHHS, EOHHS shall increase the amount in **Section 5.2.A.3.b.1** by 40% of the base rate;

For Attributed Members not attributed to a health center, as designated by EOHHS, EOHHS shall increase the amount in **Section 5.2.A.3.b.1** based on the Contractor's safety net category as follows:

EOHHS shall calculate the Contractor's payer revenue mix based on the percent of the Contractor's patient service revenue that is generated from caring for Medicaid, Children's Health Insurance Program (CHIP) or uninsured patients, as further specified by EOHHS;

EOHHS shall categorize the Contractor into one of five safety net categories based on the Contractor's calculated payer revenue mix, as further specified by EOHHS;

EOHHS shall increase the amount in Section 5.2.A.3.b.1 by a percentage based on the Contractor's safety net category as follows:

Category 5: increased by 40% of the base rate;

Category 4: increased by 30% of the base rate;

Category 3: increased by 20% of the base rate;

Category 2: increased by 10% of the base rate; or

Category 1: not increased.

The resulting base rate shall be as follows:

For Attributed Members attributed to a health center, as designated by EOHHS, after applying any increases from **Sections 5.2.A.3.b** and **5.2.A.3.d**, the resulting base rate shall be the Contractor's per-Attributed Member rate for such Attributed Members for Startup and Ongoing DSRIP payments for the Performance Year;

For Attributed Members not attributed to a health center, as designated by EOHHS, after applying any increases from **Sections 5.2.A.3.c** and **5.2.A.3.d**, the resulting base rate shall be the Contractor's per-Attributed Member rate for such Attributed Members for Startup and Ongoing DSRIP payments for the Performance Year;

EOHHS shall calculate the number of Attributed Members to use in determining each DSRIP payment, including the number of Attributed Members attributed to a health center, based on a schedule determined by EOHHS, as further specified by EOHHS;

Contractor DSTI Glide Path DSRIP Payments

EOHHS shall pay Contractor DSTI Glide Path DSRIP payments in accordance with this Section. EOHHS shall only make such payment if the Contractor has a Participating Safety Net Hospital:

EOHHS shall establish an amount of funding for each Participating Safety Net Hospital for each Performance Year, as further specified by EOHHS;

If Contractor has at least one Participating Safety Net Hospital, Contractor's total DSTI Glide Path DSRIP payment for the Performance Year shall be equal to the sum of such funding amounts for Contractor's Participating Safety Net Hospitals for the Performance Year;

EOHHS shall make such payments each Performance Year in four equal quarterly installments (two equal quarterly installments in Performance Year 0), or at another frequency and in other divisions specified by EOHHS;

A percentage of this total payment shall be withheld (and quarterly payments reduced accordingly) until the following Performance Year, as follows:

The withheld amount shall be:
0% in Performance Year 0;
5% in Performance Year 1;
5% in Performance Year 2;
10% in Performance Year 3;
15% in Performance Year 4; and
20% in Performance Year 5.

EOHHS shall multiply the withheld amount by Contractor's DSRIP Accountability Score each Performance Year, and pay the resulting amount by the end of the following Performance Year, or at a time specified by EOHHS.

Flexible Services DSRIP Payments

After July 1, 2018 or another date specified by EOHHS, EOHHS shall pay Contractor Flexible Services DSRIP payments as follows:

EOHHS shall determine a per-Attributed Member Flexible Services Allotment for each Performance Year;

EOHHS shall calculate the number of Attributed Members to use in determining Contractor's total Flexible Services Allotment each Performance Year based on a schedule determined by EOHHS, as further specified by EOHHS;

EOHHS shall establish a process by which Contractor may request reimbursement for Contractor's spending on qualified flexible services expenditures. For the purposes of this Section, "qualified

flexible services expenditures" shall be amounts paid for services that meet all of the following requirements, in EOHHS' sole determination:

Fall into an EOHHS-approved category of Flexible Services. As further specified by EOHHS, EOHHS-approved categories of Flexible Services are as follows. EOHHS reserves the right to modify these categories of Flexible Services throughout the Contract Term:
Transition services for individuals transitioning from institutional settings into community settings;
Home and Community-Based Services to divert individuals from institutional placements;
Services to maintain a safe and healthy living environment:
Physical activity and nutrition;
Experience of violence support; or
Other individual goods and services that:
Address medical needs and provide direct benefit and support specific outcomes that are identified in the Attributed Member's care plan; and
Promote the delivery of Medically Necessary services in community settings;
Decrease the need for other Medically Necessary services;
Are directly related to the health and safety of the Attributed Member in his/her home or community;

Are health-related;

Are not otherwise covered benefits under the MassHealth state plan, the MassHealth 1115 Demonstration Waiver, or other publicly-funded programs, including Home and Community-Based Waiver programs;

Are consistent with and documented in the Attributed Member's care plan;

May include, but are not limited to, classes programs, equipment, appliances or special clothing or footwear likely to improve health outcomes, prevent or delay health deterioration;

Are determined to be cost effective and informed by evidence that the service is related to health outcomes, in EOHHS' sole determination; and

Meet any additional requirements specified by EOHHS.

EOHHS shall make Flexible Services DSRIP payments to Contractor to reimburse for any such requests that are approved by EOHHS, up to a maximum of the Contractor's Flexible Services Allotment for the Performance Year during which the qualified flexible services were provided; and

EOHHS shall make Flexible Services DSRIP payments at a frequency and in a manner determined by EOHHS.
DSRIP Accountability Score

EOHHS shall calculate the Contractor's DSRIP Accountability Score based on the Contractor's performance on TCOC and Quality, as described in **Appendix B** and as further specified by EOHHS.

DSRIP Performance Remediation Plan

If the Contractor does not earn a 100% DSRIP Accountability Score, EOHHS may provide the Contractor an opportunity to submit a DSRIP Performance Remediation Plan. Such DSRIP Performance Remediation Plan is subject to EOHHS approval. Subject to EOHHS' determination of the Contractor's satisfactory performance under the EOHHS-approved DSRIP Performance Remediation Plan, the Contractor may earn a portion of its unearned withheld funds.

Conditions

All DSRIP payments are subject to federal approval and availability of funds. EOHHS reserves the right to reduce the amount of DSRIP payments or to recoup DSRIP payments if available funds are reduced, including but not limited to if federal authority for the DSRIP program is reduced according to the terms of the DSRIP program's State Accountability Protocols.

Defer DSRIP Payment

EOHHS may defer making a Performance Year's DSRIP payments by up to one year from the end of such Performance Year, as further specified by EOHHS, including but not limited to due to the availability of funds.

Early Termination

Subject to all necessary federal approvals, if the Contract is terminated prior to the end of the Contract Term, the Contractor shall pay to EOHHS a percentage of the DSRIP payments in accordance with this section.

If the Contractor terminates the Contract pursuant to **Section 5.23.B.5.a**: As further specified by EOHHS, if EOHHS terminates the Contract prior to the end of the Contract Term by EOHHS for any reason, EOHHS may require the Contractor to promptly pay to EOHHS an amount of zero percent (0%) to fifty percent (50%) of the total of all Startup and Ongoing and DSTI Glide Path DSRIP payments that the Contractor has received through the effective date of the Contract's termination;

As further specified by EOHHS, the Contractor shall promptly pay to EOHHS the percentage specified below of all Startup and Ongoing and DSTI Glide Path DSRIP payments that the Contractor has received through the effective date of the Contract's termination as follows:

If the Contractor terminates the Contract pursuant to **Section 5.23.B.5.a**:
And the Contract termination is effective at the end of Contract Year 2, the Contractor shall pay to EOHHS seventy-five percent (75%) of such received DSRIP payments described above;
And the Contract termination is effective at the end of Contract Year 3, the Contractor shall pay to EOHHS seventy-five percent (75%) of such received DSRIP payments described above;

AND THE CONTRACT TERMINATION EFFECTIVE AT THE END OF CONTRACT YEAR 4, THE CONTRACTOR SHALL PAY TO EOHHS FIFTY PERCENT (50%) OF SUCH RECEIVED DSRIP PAYMENTS DESCRIBED ABOVE;

IF THE CONTRACTOR TERMINATES THE CONTRACT PURSUANT TO **SECTION 5.23.B.5.B**:
AND THE CONTRACT TERMINATION IS EFFECTIVE AT THE END OF CONTRACT YEAR 2, THE CONTRACTOR SHALL PAY TO EOHHS FIFTY PERCENT (40%) OF SUCH RECEIVED DSRIP PAYMENTS DESCRIBED ABOVE;
AND THE CONTRACT TERMINATION IS EFFECTIVE AT THE END OF CONTRACT YEAR 3, THE CONTRACTOR SHALL PAY TO EOHHS THIRTY-FIVE PERCENT (30%) OF SUCH RECEIVED DSRIP PAYMENTS DESCRIBED ABOVE;
AND THE CONTRACT TERMINATION IS EFFECTIVE AT THE END OF CONTRACT YEAR 4, THE CONTRACTOR SHALL PAY TO EOHHS THIRTY PERCENT (25%) OF SUCH RECEIVED DSRIP PAYMENTS DESCRIBED ABOVE;

THE CONTRACTOR IS NOT REQUIRED TO PAY TO EOHHS ANY DSRIP PAYMENTS IF THE CONTRACTOR TERMINATES THE CONTRACT PURSUANT TO **SECTION 5.23.B.4** OR **SECTION 5.23.B.6**.

OTHER

The Parties shall execute a separate DSRIP payment agreement in a form and format specified by EOHHS and shall comply with all provisions in this **Section 4** and such agreement.

Technical Assistance and Additional Supports

EOHHS may provide additional supports to the Contractor with accessing technical assistance for DSRIP-related activities as follows:

Technical Assistance

Technical assistance may include but not be limited to areas such as:

Population health management;

Financial accountability and risk management;

Identifying and evaluating return on investment for care management programs and strategies;

EHR and IT, including infrastructure, support, and training;

Member engagement;

Clinical quality; and

Other areas identified by Contractor or EOHHS.

EOHHS Support

EOHHS support may include but not be limited to activities such as:

Establishing an approved vendor list to provide technical assistance; and

Arranging discounted rates on technical assistance from such vendors; and

EOHHS may establish additional requirements, including but not limited to reporting requirements, for the Contractor and make such support conditional on such requirements.

ADDITIONAL CONTRACT TERMS AND CONDITIONS

CONTRACT TERM

The Contract awarded under this RFR shall be effective upon execution and end on December 31, 2022; provided, however, that EOHHS may extend the Contract in any increments up to June 30, 2028, at the sole discretion of EOHHS, upon terms agreed upon by the parties. EOHHS reserves the right to further extend the Contract for any reasonable increment it determines necessary to complete a subsequent procurement. Extension of the Contract is subject to future legislative appropriations, continued legislative authorization, and EOHHS' determination of satisfactory performance.

[RESERVED]

NOTIFICATION OF ADMINISTRATIVE CHANGE

The Contractor shall notify EOHHS in writing no later than 30 days prior to any change affecting it, or its performance of its responsibilities under this Contract, but if a change in business structure is voluntary, the Contractor shall provide a minimum of three months' notice to EOHHS.

ASSIGNMENT

The Contractor shall not assign or transfer any right, interest, or obligation under this Contract to any successor entity or other entity without the prior written consent of EOHHS.

INDEPENDENT CONTRACTOR

The Contractor, its employees, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of EOHHS or the Commonwealth of Massachusetts.

PROGRAM MODIFICATIONS AND NEW INITIATIVES

A. EOHHS shall have the option at its sole discretion to modify, increase, reduce or terminate any activity related to this Contract whenever, in the judgment of EOHHS, the goals of the project have been modified or altered in a way that necessitates such changes. In the event that the scope of work or portion thereof must be changed, EOHHS shall provide written notice of such action to the Contractor and the parties shall negotiate in good faith to implement any such changes proposed by EOHHS.

B. EOHHS additionally reserves the right, at its sole discretion, to amend the Contract to implement state or federal statutory or regulatory requirements, judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS or the Contract.

C. Notwithstanding the generality of the foregoing, EOHHS reserves the right to amend the Contract to implement new initiatives or to modify initiatives related to:

New EOHHS programs or information technology systems, including but not limited to managed care programs and enrollment policies, accountable care organization and other payment reform initiatives;

Expansion of, or changes to, existing EOHHS programs, covered benefits, services, or information technology systems, including but not limited to programs related to managed care programs and enrollment policies, accountable care organizations and other payment reform initiatives and Emergency Services Programs;

Adding Long-Term Services and Supports as TCOC Included Services beginning on around Contract Year 3.

Such services and supports may include services such as the following:
Inpatient Chronic Disease & Rehab Hospitals (post-100 days of service);
Outpatient Chronic Disease & Rehab Hospitals (post-100 days of service);
Nursing Facilities (post-100 days of service);
Adult Day Health;
Adult Foster Care;
Group Adult Foster Care;
Day Habilitation;
Continuous skilled nursing; and
Personal Care Attendant (to include Transitional Living Program).

The Contractor may also be required to perform activities associated with the provision of such services, such as:
Readiness activities prior to Contract Year 3, including but not limited to a showing of policies and protocols sufficient to meet the assessment, care coordination, and care management needs of Attributed Members in need of LTSS, including partnerships with LTSS CPs as described in **Section 2.3.G**;
Readiness to submit LTSS-related reports;
Financial readiness to take on LTSS responsibility; and
Additional responsibilities related to assessment and care planning, and integrated care management.

ADDING EXPANDED SUBSTANCE USE DISORDER SERVICES AS TCOC INCLUDED SERVICES, WHICH MAY INCLUDE BUT MAY NOT BE LIMITED TO TRANSITIONAL SUPPORT SERVICES AND RESIDENTIAL REHABILITATION SERVICES, AS DIRECTED BY EOHHS;

ADDITION REQUIREMENTS RELATED TO SUPPORTING ACCESS, COORDINATION, AND CONTINUITY OF BEHAVIORAL HEALTH CARE, SUCH AS THOSE DESCRIBED IN **SECTION 2.3.C.4.H**;

REQUIRING THE CONTRACTOR TO ENHANCE ITS POLICIES AND PROCEDURES FOR PROMOTING INFORMATION SHARING, CERTIFIED ELECTRONIC HEALTH RECORD (EHR) SYSTEMS, AND MASS HIWAY CONNECTIONS, INCLUDING REQUIRING ALL PARTICIPATING PCCS TO SUBSCRIBE TO A STATEWIDE EVENT NOTIFICATION SERVICE ONCE IT HAS BEEN DEVELOPED BY EOHHS;

IMPLEMENTATION OF OTHER INITIATIVES IN EOHHS' DISCRETION CONSISTENT WITH DELIVERY SYSTEM REFORM EFFORTS OR OTHER MASSHEALTH POLICY OR GOALS;

OTHER PROGRAMS AS SPECIFIED BY EOHHS; AND

PROGRAMS OR INFORMATION TECHNOLOGY SYSTEMS RESULTING FROM STATE OR FEDERAL LEGISLATION, INCLUDING BUT NOT LIMITED TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) OF 2010, AND REGULATIONS, INITIATIVES, OR JUDICIAL DECISIONS THAT MAY AFFECT IN WHOLE OR IN PART EOHHS OR THE CONTRACT.

D. The parties shall negotiate in good faith to implement any such initiatives proposed by EOHHS. The Contractor's responsibilities are subject to change due to implementation of such initiatives. EOHHS reserves the right to modify the Contract due to program modifications. In addition, the Contractor may request an opportunity to enter into negotiations with EOHHS over amendments to the Contract related to new initiatives or modified initiatives as described in this Section. EOHHS may grant such a request in its sole discretion.

E. Any changes under this Section shall be subject to appropriate approvals.

INTELLECTUAL PROPERTY

DEFINITIONS

With respect to intellectual property rights described in this **Section 5.7**, the following terms have the following meaning:

CONTRACTOR PROPERTY MEANS ALL INTELLECTUAL PROPERTY DEVELOPED BY CONTRACTOR, INCLUDING ALL COPYRIGHT, PATENT, TRADE SECRET, TRADEMARK AND OTHER INTELLECTUAL PROPERTY RIGHTS CREATED BY THE CONTRACTOR IN CONNECTION WITH SUCH INTELLECTUAL PROPERTY

EOHHS PROPERTY MEANS ALL INTELLECTUAL PROPERTY DEVELOPED BY OR FOR EOHHS THAT IS NOT CONTRACTOR PROPERTY, INCLUDING ALL COPYRIGHT, PATENT, TRADE SECRET, TRADEMARK AND OTHER INTELLECTUAL PROPERTY RIGHTS CREATED BY OR FOR EOHHS (INCLUDING THE WORK PRODUCT OF EOHHS SUBCONTRACTORS AND VENDORS) RELATED TO THE CREATION, MANAGEMENT OR IMPLEMENTATION OF EOHHS' ACO PROGRAM. FOR THE SAKE OF CLARITY, IT IS UNDERSTOOD AND AGREED BY EOHHS AND CONTRACTOR THAT THE WORK PRODUCT OF EOHHS SUBCONTRACTORS AND VENDORS DOES NOT INCLUDE CONTRACTOR'S WORK PRODUCT.

Contractor Property

The Contractor will retain all right, title and interest in and to all Contractor Property. EOHHS acknowledges that its possession or use of Contractor Property will not transfer to it any title to such intellectual property.

The Contractor shall have all the rights, incidents and obligations of ownership with respect to the Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties.

Nothing in this **Section 5.7** shall limit the Contractor's obligations set forth in this Contract, including but not limited to the obligations set forth in **Section 2**.

Nothing in this Contract shall be construed as a waiver by EOHHS of any rights and obligations under Federal Regulations, including, but not limited to, 45 CFR Section 75.322.

EOHHS Property and Data

EOHHS will retain all right, title and interest in and to all EOHHS Property. The Contractor acknowledges that its possession or use of EOHHS Property will not transfer to it any title to such intellectual property.

EOHHS shall have all the rights, incidents and obligations of ownership with respect to EOHHS Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties.

The Contractor shall not disseminate, reproduce, display or publish any EOHHS Property except in accordance with the terms and pursuant to its obligations under this Contract without the prior written consent of EOHHS.

All data acquired by the Contractor from EOHHS or from others on behalf of EOHHS in the performance of this Contract (including personal data, if any) remain the property of EOHHS. The Contractor agrees to provide EOHHS free and full access at all reasonable time to all such data, regardless of whether the data is stored by the Contractor or, where applicable, its subcontractors.

The Contractor shall not use EOHHS-owned data, materials and documents, before or after termination or expiration of this Contract, except as required for the performance of the services hereunder.

The Contractor shall return to EOHHS promptly, but in any event no later than one week after EOHHS's request, EOHHS-owned or Commonwealth-owned data, and EOHHS Property. If such return is not feasible, the Contractor shall, at EOHHS's direction, destroy all EOHHS- or Commonwealth-owned data and/or EOHHS Property.

NO THIRD-PARTY ENFORCEMENT

This Contract shall be enforceable only by the parties, or officers or agencies of the Commonwealth authorized to act on behalf of EOHHS or its successors. Nothing in this Contract shall be deemed to confer benefits or rights to any other parties.

Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void and any such invalidity shall not affect the validity of the remainder of this Contract.

Authorizations

This Contract is subject to all necessary federal and state approvals.

Prohibited Activities and Conflict of Interest

The Contractor certifies and agrees that it, its employees, affiliates, subcontractors, consultants, and those who have a contract with the Contractor shall:

A. Not have any interest that conflicts with the performance of services under the Contract for the duration of the Contract, as determined by EOHHS. The Contractor shall inform EOHHS of any potential conflict of interest, in any degree, arising during the term of this Contract.

B. Not have been debarred by any federal agency, excluded from participation in a program under Titles XVIII, XIX, or XXI of the Social Security Act, or subjected to a civil money penalty under the Social Security Act.

C. In accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded, under federal or state law, regulation, executive order, or guidelines, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity nor be permitted to serve as a director, officer or partner of the Contractor.

D. The Contractor shall not meet any of the conditions set forth in 42 CFR 438.808(b).

Compliance with Laws

A. The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract

as they become effective, including, for the avoidance of doubt, applicable laws relating to the privacy or security including but not limited to those identified by EOHHS, as well as applicable antitrust laws and regulations, federal and state laws and regulations designed to prevent fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq) and the anti-kickback statute (42 U.S.C. s. 1320a-7b(b)) and M.G.L. ch. 118E s.41, federal and state laws pertaining to Member rights, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles

II and III of the American with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act. EOHHS may unilaterally amend this agreement in order to ensure compliance with such laws and regulations.

B. The Contractor shall promptly execute and comply with any amendment to this Contract that EOHHS determines is necessary to ensure compliance with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.

AMENDMENTS

The parties may amend this Contract where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided such amendment is in writing, signed by both parties, and attached hereto. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

EOHHS and Contractor mutually acknowledge that unforeseen policy, operational, methodological, or other issues may arise throughout the course of this Contract. Accordingly, EOHHS and Contractor agree to work together in good faith to address any such circumstances and resolve them, and if necessary will enter into amendments to this Contract on mutually agreeable terms.

COUNTERPARTS

This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original, and all of which together will constitute one and the same instrument.

SECTION HEADINGS

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

WAIVER

EOHHS' exercise or non-exercise of any authority under this Contract, including, but not limited to, review and approval of materials submitted in relation to the Contract or of privacy or security practices, shall not relieve the Contractor of any obligations set forth herein, nor be construed as a waiver of any of the Contractor's obligations or as acceptance by EOHHS of any unsatisfactory practices or breaches by the Contractor.

RECORD KEEPING, QUALITY REVIEW, AUDIT, AND INSPECTION OF RECORDS

A. The Contractor shall maintain all books, records and other compilations of data pertaining to the performance of the provisions and requirements of the Contract, as determined by EOHHS, to the extent and in such detail as shall properly substantiate claims for payment under the Contract and in accordance with the requirements in Section 7 of the Commonwealth Terms and Conditions. Specifically, the Contractor shall:

MAINTAIN ALL PERTINENT RECORDS IN A COST-EFFECTIVE AND EASILY RETRIEVABLE FORMAT.

MAINTAIN AN OFF-SITE STORAGE FACILITY FOR EOHHS-SPECIFIED RECORDS THAT IS OUTSIDE OF THE DISASTER RANGE OF THE CONTRACTOR'S PRINCIPAL PLACE OF BUSINESS AND THE MEETS RECOGNIZED INDUSTRY STANDARDS FOR PHYSICAL AND ENVIRONMENTAL SECURITY.

TAKE ALL REASONABLE AND NECESSARY STEPS TO PROTECT THE PHYSICAL SECURITY OF PERSONAL DATA OR OTHER DATA AND MATERIALS USED BY THE CONTRACTOR. THE PROTECTION OF PHYSICAL SECURITY SHALL MEAN PREVENTION OF UNAUTHORIZED ACCESS, DISSEMINATION, MISUSE, REPRODUCTION, REMOVAL OR DAMAGE TO DATA OR MATERIALS USED BY OR IN THE POSSESSION OF THE CONTRACTOR.

IMMEDIATELY NOTIFY EOHHS BOTH ORALLY AND IN WRITING IF THE CONTRACTOR HAS ANY REASON TO BELIEVE THAT ANY DATA APPLICABLE TO THE CONTRACT HAVE BEEN IMPROPERLY ACCESSED, DISSEMINATED, MISUSED, COPIED OR REMOVED.

B. EOHHS, the Governor, the Secretary of Administration and Finance, the Comptroller, the State Auditor, the Attorney General, or any of their duly authorized representatives or designees, or any other state or federal oversight agency shall the have the right at reasonable times and upon reasonable notice to:

   1. Examine and copy books, records, and other compilations of data pertaining the performance of this Contract;

   2. Evaluate through inspection or other means the quality, appropriateness, and timeliness of the Contractor's performance under the Contract; and

   3. Inspect and audit the financial records of the Contractor and its subcontractors related to the performance of this Contract.

For the avoidance of doubt, nothing in this **Section 5.17** shall limit the right of access set forth in **Section 6** of this Contract.

REQUIREMENTS FOR SUBCONTRACTORS

In addition to the provisions of Section 9 of the Commonwealth Terms and Conditions, the following provisions shall apply to all subcontracts:

A. The Contractor shall hire subcontractors in performing the requirements of this Contract only with EOHHS' prior approval. To obtain such approval, the Contractor shall make a request in writing and

submit with that request a completed Material Subcontractor checklist using the template provided by EOHHS and attached hereto as **Appendix K**, as may be modified by EOHHS from time-to-time, at least 60 days prior to the date the Contractor expects to execute the Material Subcontract.

B. The Contractor shall maintain in writing all subcontracts relating to this Contract.

C. All subcontractors and subcontracts are subject to EOHHS' approval, which may include reviewing any subcontract documents or contracts or processes, meeting with the perspective subcontractor, or requiring resumes of the subcontractor's key personnel.

D. All such subcontracts must contain all relevant provisions of this Contract and Commonwealth Terms and Conditions appropriate to the subcontracted service or activity and all terms of such subcontracts must be consistent with all terms and conditions of this Contract. Without limiting the generality of the foregoing, the Contractor must ensure that it complies with all applicable privacy and security provisions with respect to any subcontractor that uses, maintains, discloses, receives, creates or otherwise obtains personal information.

E. The Contractor must obligate in writing all such subcontractors to comply with all data privacy and data security provisions, including any obligations that the Contractor undertakes under any confidentiality agreements pertaining to personal data or protected health information as may be required under HIPAA or other state or federal law.

F. The Contractor is fully responsible for any subcontractor's performance and for meeting all terms and requirements of this Contract. The Contractor will not be relieved of any legal obligation under this Contract, regardless of whether the Contractor subcontracts for performance of any Contract responsibility. Without limiting the generality of the foregoing, the Contractor shall not be relieved of any obligation or condition under this Contract because personal information personal information or other information was in the hands of a subcontractor.

ENTIRE AGREEMENT

This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract shall prevail notwithstanding any variances with the terms and conditions of any written or verbal communication subsequently occurring, except as otherwise provided herein.

RESPONSIBILITY OF THE CONTRACTOR

The Contractor is responsible for the professional quality, technical accuracy, and timely completion and delivery of all services furnished by the Contractor under this Contract. The Contractor shall, without

additional compensation, correct or revise any errors, omissions, or other deficiencies in its deliverables and other services.

Administrative Procedures Not Covered

Administrative procedures not provided for in this Contract will be set forth where necessary in separate memoranda from time to time.

Remedies for Poor Performance

EOHHS may seek remedies for poor performance on the part of the Contractor under this Contract. If the Contractor fails to perform in a manner that is satisfactory to EOHHS, EOHHS may take one or more of the following actions:

A. Require the Contractor to develop and submit a corrective action plan for EOHHS' review and approval. EOHHS shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. EOHHS may also initiate a corrective action plan for the Contractor to implement. The Contractor shall promptly and diligently implement the corrective action plan as approved by EOHHS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by EOHHS;

B. Require the Contractor to amend its Approved ACO Agreement(s)to change the Contractor's Risk Track as defined in **Section 2.7.B**; or

C. Terminate the Contract with or without cause as EOHHS determines appropriate.

Termination

Termination without Prior Notice

EOHHS may terminate this Contract immediately and without prior written notice upon any of the events below. EOHHS shall provide written notice to the Contractor upon such termination.

The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

The Contractor's admission in writing that it is unable to pay its debts as they mature;

The Contractor's assignment for the benefit of creditors;

Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceedings;

COMMENCEMENT OF AN INVOLUNTARY PROCEEDING AGAINST THE CONTRACTOR OR SUBCONTRACTOR UNDER ANY BANKRUPTCY, REORGANIZATION, INSOLVENCY, OR READJUSTMENT OF DEBT PROVISION OF FEDERAL OR STATE LAW WHICH IS NOT DISMISSED WITHIN SIXTY DAYS; OR

CESSATION IN WHOLE OR IN PART OF STATE OR FEDERAL FUNDING FOR THIS CONTRACT, PROVIDED THAT TERMINATION FOR THIS REASON SHALL OCCUR NO EARLIER THAN THE LAST DAY OF THE MONTH IN WHICH SUCH FUNDING CEASES.

TERMINATION WITH PRIOR NOTICE

EOHHS MAY TERMINATE THIS CONTRACT UPON BREACH BY THE CONTRACTOR OF ANY DUTY OR OBLIGATION HEREUNDER WHICH BREACH CONTINUES UNREMEDIED FOR 30 DAYS AFTER WRITTEN NOTICE THEREOF BY EOHHS.

EOHHS may terminate this Contract after written notice thereof to the Contractor in the event the Contractor fails to accept any TCOC Benchmark established by the Contracting MCO.

EOHHS may terminate this Contract if EOHHS determines that the ACO Program is not performing in whole or in part in accordance with EOHHS' expectations (even if financial losses are less than three percent (3%) of the Non-HCV TCOC Benchmark) or that state or federal health care reform initiatives or state or federal health care cost containment initiatives makes termination of the Contract necessary or advisable as determined by EOHHS.

The Contractor may terminate this Contract upon a material breach by EOHHS of a duty or obligation in **Section 2.7** or **Section 4** of this Contract that creates significant challenges for the Contractor to continue performing under this Contract. In the event that the Contractor terminates this Contract pursuant to this section, subject to all necessary federal approvals, the Contractor shall not be obligated to return DSRIP payments as described in **Section 4.2.H**.

Contractor Options to Terminate Starting in Contract Year 2

As further specified by EOHHS in accordance with **Section 5.23.B.7**, starting in Contract Year 2, the Contractor may terminate this Contract annually without cause by providing written notice to EOHHS prior to the start of the next Contract Year. In the event that the Contractor terminates this Contract pursuant to this Section:
Such termination will be effective at 11:59 PM of the last day of the current Contract Year (the earliest Contract Year being the end of Contract Year 2), unless otherwise specified by EOHHS in accordance with **Section 5.23.B.7**;
EOHHS shall calculate Shared Savings or Shared Losses as described in **Section 2.7**, if any, for the Contract Year in which the termination is effective. The Contractor shall promptly pay EOHHS any Shared Losses. EOHHS shall not be obligated to pay the Contractor any Shared Savings; and
Subject to all necessary federal approvals, the Contractor shall promptly pay EOHHS a specified percentage of Startup and Ongoing and DSTI Glide Path DSRIP payments as set forth in **Section 4.2.H**;

As further specified by EOHHS in accordance with **Section 5.23.B.7**, starting in Contract Year 2, the Contractor may terminate this Contract annually as further specified by EOHHS by providing written notice to EOHHS prior to the start of the next Contract Year with validated data showing significant financial losses in the most recently completed Contract Year and anticipated further significant financial losses in the current Contract Year. For the purposes of this section, significant financial losses shall mean greater than three percent (3%) of Non-HCV component of the TCOC Benchmark.
In the event that the Contractor terminates this Contract pursuant to this Section:
Such termination will be effective at 11:59 PM of the last day of the current Contract Year (the earliest Contract Year being the end of Contract Year 2), unless otherwise specified by EOHHS in accordance with **Section 5.23.B.7**;

EOHHS shall calculate Shared Savings or Shared Losses as described in **Section 2.7**, if any, for the Contract Year in which the termination is effective. The Contractor shall promptly pay EOHHS any Shared Losses. EOHHS shall not be obligated to pay the Contractor any Shared Savings; and
Subject to all necessary federal approvals, the Contractor shall promptly pay EOHHS a specified percentage of Startup and Ongoing and DSTI Glide Path DSRIP payments as set forth in **Section 4.2.H**.

As further specified by EOHHS in accordance with **Section 5.23.B.7**, the Contractor may terminate this Contract by providing written notice of termination within 30 days after EOHHS notifies the Contractor that, in EOHHS' sole determination, EOHHS finds that the Contractor has significant programmatic cause for exit, as follows and as further specified by EOHHS:

The Contractor may request a finding of significant programmatic cause for exit from EOHHS at any time by submitting a written request to EOHHS in a form and format specified by EOHHS. Such request shall include any information the Contractor deems relevant to its request;

The Contractor shall provide any additional information requested by EOHHS related to the Contractor's request for a finding of significant programmatic cause for an exit;

EOHHS may, but is not obligated to, find significant programmatic cause for exit for the following reasons:
Losses greater than five percent (5%) of the Non-HCV component of the TCOC Benchmark in the last two completed Contract years; or
The Contractor or its Participating PCPs have merged with another ACO in the MassHealth ACO program, and the Contractor's Participating PCPs have all received EOHHS approval to terminate their affiliation with the Contractor and to affiliate as Participating PCPs with such ACO pursuant to **Section 3.6**;

EOHHS will find significant programmatic cause for exit if specific significant federal or state changes to the structure of the Medicaid program have occurred or are likely to occur that substantially change the demographic or risk profile of the Contractor's Enrollees in a way that makes the Contractor likely to experience significant Shared Losses in future Contract Years and have not otherwise been accounted for in EOHHS' rate setting process;

In the event that the Contractor terminates this Contract pursuant to this Section:
Such termination shall be effective at 11:59 PM of the last day of the current Contract Year (the earliest Contract Year being the end of Contract Year 2), unless otherwise specified by EOHHS in accordance with **Section 5.23.B.7**;
EOHHS shall calculate Shared Savings or Shared Losses as described in **Section 2.7.B**, if any, for the current Contract Year. The Contractor shall promptly pay EOHHS any Shared Losses, and EOHHS shall promptly pay the Contractor any Shared Savings, as described in **Section 2.7.B**;
Subject to all necessary federal approvals, the Contractor shall not be obligated to pay EOHHS any DSRIP payments as described in **Section 4.2.H**;

EOHHS shall establish and notify the Contractor of an annual process for the Contractor to terminate the Contract pursuant to **Section 5.23.B.5-6** and the earliest date the Contractor may initiate such process. Such process will, in part, provide the Contractor information about its performance for the most recently completed Contract Year. The Contractor shall terminate this Contract pursuant to **Section 5.23.B.5-6** only as described by EOHHS' defined process.

Continued Obligations of the Parties

In the event of termination, expiration or non-renewal of this Contract, the obligations of the parties hereunder with regard to each Attributed Member at the time of such termination, expiration or non-renewal will continue until the Attributed Member has been transferred from the Contractor.

In the event that this Contract is terminated, expires, or is not renewed for any reason: (1) EOHHS, or its designee, shall be responsible for notifying all Attributed Members covered under this Contract of the date of termination and the process by which those Attributed Members will continue to receive medical care; and (2) the Contractor shall supply to EOHHS, or its designee, all information necessary for the payment of any outstanding payments determined by EOHHS to be due to the Contractor, and any such payments shall be paid to the Contractor accordingly.

In the event this Contract is terminated, expires, or is not renewed for any reason, the Contractor shall, to facilitate the transition of Attributed Members to another MassHealth ACO, share information with the Contracting MCO relating to its Attributed Members, including but not limited to PCP assignments, Attributed Members in care management, and Attributed Members with relationships with Community Partners. The Contractor shall, if applicable, provide any information to the Contracting MCO regarding Participating PCPs for the purposes of smoothly transitioning patients and maintaining continuity of care.

Termination Authority

The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

Suspected Fraud

The Contractor shall notify EOHHS in writing within ten (10) calendar days if it or, where applicable, any of its subcontractors receive or identify any information that gives them reason to suspect that an EOHHS client or Commonwealth contractor has engaged in fraud as defined under 42 CFR 455.2 or other applicable law. In the event of suspected fraud, no further contact shall be initiated with such client or contractor on that specific matter without EOHHS' approval.

The Contractor and, where applicable, its subcontractors shall cooperate, as reasonably requested in writing, with the Office of the Attorney General's Medicaid Fraud Division (MFD), the Office of the State Auditor's Bureau of Special Investigations (BSI), or other applicable enforcement agency. 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 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.

Restrictions of Use of the Commonwealth Seal

Bidders and Contractors 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.

Order of Precedence

The Contractor's response and RFR specified below are incorporated by reference into this Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

A. This Contract, including any amendments hereto;

B. The Request for Responses for Accountable Care Organizations issued by EOHHS on September 29, 2016; and

C. The Contractor's Response to the RFR.

Contractor's Financial Condition and Corporate Structure

As a condition of the Contract, the Contractor shall, at the request of EOHHS, provide EOHHS with documentation relating to organizational structure, financial structure and solvency, including but not limited to the following: the name(s) and address(es) of the (1) Contractor's parent organizations, (2) parents of such parent organizations, (3) Contractor's subsidiary organizations, and (4) subsidiaries of any organizations listed in (1), (2), or (3) herein; and the names and occupations of the members of the Board of Directors of the organizations listed in (1)-(4) herein.

NOTICES

Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail (return receipt requested), postage prepaid, or delivered in hand or by an overnight delivery service with acknowledgment of receipt:

To EOHHS:

Assistant Secretary for MassHealth

Executive Office of Health and Human Services

One Ashburton Place, 11th Floor

Boston, MA 02108

To MassHealth:

Director, MassHealth ACO Program

Executive Office of Health and Human Services

One Ashburton Place, 2nd Floor

Boston, MA 02108

Director, ACO Program Administration

Executive Office of Health and Human Services

One Ashburton Place, 2nd Floor

Boston, MA 02108

With Copies to:

General Counsel

Executive Office of Health and Human Services

One Ashburton Place, 11th Floor

Boston, MA 02109

To the Contractor:

Katherine L. Record

Lahey Clinical Performance Network, LLC

41 Mall Road

Burlington, MA, 01805

DATA MANAGEMENT AND CONFIDENTIALITY

The Contractor shall comply with all state and federal laws and regulations applicable to the privacy and security of personal and other confidential information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the privacy and security regulations promulgated thereunder (45 CFR Parts 160 and 164) (the Privacy and Security Rules), and any other legal obligations regarding the privacy and security of such information to which the Contractor is subject, including any obligations to which the Contractor is subject by virtue of its contractual relationship with its Participating Providers. The Contractor shall also comply with the additional terms, conditions and obligations relating to the privacy, security and management of personal and other confidential information determined by EOHHS to apply to this Contract. If the Contractor is determined to be EOHHS' Business Associate under the Privacy and Security Rules with respect to any function or activity contemplated herein, the Contractor shall execute a Business Associate agreement with EOHHS.

EOHHS reserves the right to amend the Contract to add any requirement it determines must be included in the Contract in order for EOHHS to comply with the all applicable state and federal laws and regulations relating to privacy and security, including but not limited to the Privacy and Security Rules and any other legal obligations regarding the privacy and security of such information to which EOHHS is subject.

If the Contractor wishes to receive member-level data or reports that may be available from EOHHS under the Contract, the Contractor may be required to submit a request to EOHHS and execute a Data Use Agreement containing any representations and/or privacy and security requirements applicable to the data and/or report(s) that EOHHS may determine necessary or appropriate.

The Contractor shall seek and obtain EOHHS prior written authorization for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract. The Contractor shall submit to EOHHS the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

The Contractor shall promptly execute and comply with any amendment to this Contract that EOHHS determines is necessary to ensure compliance with such applicable laws, regulations, and other legal obligations. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.