APPENDIX E-1

PROGRAM REPORTING REQUIREMENTS

This Appendix summarizes the programmatic reporting requirements described in the Contract. In accordance with **Section 2.14** of the Contract, the Contractor shall submit the report and corresponding Certification Checklist of all reports/submissions listed in **Appendix E** within the timelines specified herein.

For reports that have a performance target, the Contractor shall complete a narrative that includes the results, an explanation as to how the Contractor met the target or why it did not meet the target, and the steps the Contractor is taking to improve performance going forward.

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

All exhibits referenced herein pertain to **Appendix E**, unless otherwise noted. Such exhibits set forth the form and format the Contractor shall use for each report. These exhibits shall be provided to the Contractor and may be updated by EOHHS from time to time, without a Contract amendment. EOHHS shall notify the Contractor of any updates to the exhibits.

The Contractor shall prepare and submit to EOHHS the reports described in this Appendix, as well as ad hoc reports that may be requested by EOHHS. General requirements for report submissions, including instructions on formatting and data handling, are set forth in **Section 2.14** of the Contract. In the event of any inconsistency between the descriptions in this Appendix and the provisions in the Contract, the Contract controls.

Reporting Timetables

The Contractor shall provide reports to EOHHS according to the following timetable, unless otherwise specified or approved by EOHHS. All references to "annual" or "year-to-date" reports or data refer to the Contract Year, unless otherwise specified.

Reportable Adverse Incidents – Use secure e-mail system to send Reportable Adverse Incident reports to EOHHS by 5:00 p.m. (Eastern Time) on the same day that the Contractor receives Reportable Adverse Incident notification by 3:00 p.m. on a business day, in accordance with the established protocol. Submit Reportable Adverse Incident reports to EOHHS by the next business day if the Contractor receives Reportable Adverse Incident notification after 3:00 p.m. or on a non-business day, in accordance with the established protocol, unless otherwise approved by EOHHS.

Daily Reports – no later than 5:00 p.m. on the next business day following the day reported.

Weekly Reports – no later than 5:00 p.m. the next business day following the week reported.

Monthly Reports – no later than 5:00 p.m. on the 20th day of the month immediately following the month reported for non-Claims-based reports; Claims-based reports will allow for a 90-day Claims lag. If the 20th of the month falls on a non-business day, the reports will be due on the next business day. Monthly reports due October 20, January 20, April 20, and July 20 may be submitted with quarterly reports.

Quarterly Reports – no later than 5:00 p.m. on the 30th day of the month following the end of the quarter reported, for non-Claims-based reports, i.e., October 30, January 30, April 30, and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Quarterly reports due January 30th will be submitted on February 15th and July 30th will be submitted August 15th. Claims-based reports shall allow for a 90-day Claims lag and report time, so that, for example, reports due on October 30th will present data for service dates for the quarter from April-June.

Semiannual Reports – no later than 5:00 p.m. on the 30th day following the end of the semiannual period reported, for non-Claims-based reports, i.e., January 30 and July 30; or, if the 30th of the month falls on a non-business day, the next business day. Semiannual reports are due August 30th for January – June. Reports due February 15th are for July – December. Claims-based reports shall allow for a 90-day Claims lag, so that, for example, the report due on January 30th will present data through September 30th.

Annual Reports – no later than 5:00 p.m. on February 15th or, if February 15th falls on a non-business day, the next business day. Claims-based annual reports will allow for a 90-day Claims lag, so data due on February 15th will be for Claims no later than September.

One-time, Periodic, and Ad Hoc Reports – no later than the time stated, or as directed by EOHHS.

Reportable Adverse Incidents

1. BEHAVIORAL HEALTH REPORTABLE ADVERSE INCIDENTS AND ROSTER OF REPORTABLE ADVERSE INCIDENTS – DAILY INCIDENT DELIVERY REPORT – BH-01

Report of Reportable Adverse Incidents that comes to the attention of the Contractor.

One-time, Periodic and Ad Hoc Reports

2. AUTHORIZATION REPORTS FOR CBHI SERVICES – BH-N/A

Summary report of authorizations units of services requested, approved and denied for CBHI Services.

3. NETWORK PROVIDER PROTOCOLS

The Contractor shall notify EOHHS when it terminates a Provider within three (3) business days of such termination.

4. ADDITIONAL REPORTS AND REPORTING ACTIVITIES (FOR PCC PLAN)

The Contractor shall produce additional PMSS reports, including but not limited to analysis of trends identified from PMSS data, data and analytics on population health management,

and other supplemental and management reports that support quality and integration activities as negotiated by the parties.

5. PROVIDER AND PCC QUALITY FORUMS

The Contractor shall provide a summary report on each series of quality forums described in **Section 2.13**. The report shall include, at a minimum, information on the number and type of attendees (profession and practice name), the location, the presentation topic and responses from attendees regarding the quality of the program presented. The report shall be submitted within 30 days after the last session of a forum series.

6. PCC CLINICAL ADVISORY COMMITTEE

The PCC Clinical Advisory Committee shall report on minutes to the meeting and provide follow-up on action items established.

9. BEHAVIORAL HEALTH URGENT CARE – AD HOC REPORTS

Provide any Behavioral Health Urgent Care ad hoc reports further specified by EOHHS.

Daily Reports

16. DEPARTMENT OF MENTAL HEALTH (DMH) DAILY ADMISSIONS – BH-17

Report of DMH Clients who were admitted to Behavioral Health 24-hour Level-of-Care services. (Report provided to DMH.)

17. COVERED INDIVIDUALS BOARDING IN EMERGENCY DEPARTMENTS OR ON ADMINISTRATIVELY NECESSARY DAYS (AND) STATUS – BH-26

Report on any Covered Individuals awaiting placement in a 24-hour level of behavioral health care that remains in an emergency department for 24 hours or longer, as further specified by EOHHS. For AND Report, report on any Covered Individuals in AND status as described in **Appendix A-1,** in a format agreed to by EOHHS.

Weekly Reports

18. CBHI ACCESS REPORTING

Ensure that the Behavioral Health Service Access System is updated at least once a week for CBHI Services (ICC, IHBS, TM, and IHT) to show access and availability. CBHI Service reporting must be available to the public on the system.

Monthly Reports

19. CBHI SERVICES PROVIDER MONITORING REPORTS – BH-N/A

a. Provider access reports: Aggregated by Region and by service – including In-Home Therapy, Therapeutic Mentoring and In-Home Behavioral Services.

   "MABH Access (Availability and Waitlist Report)- IHT": Self-reported provider-level data

   "MABH Access (Availability and Waitlist Report)- TM": Self-reported provider-level data

"MABH Access (Availability and Waitlist Report)- IHBS": Self-reported provider-level data

"Provider Detail Report": Summary of IHT/IHBS/FST/TM providers by region

b. Provider access reports: Provider-specific data on capacity, access and wait times for In-Home Therapy, Therapeutic Mentoring and In-Home Behavioral Services.

"IHT/TM/IHBS Monthly Provider Report and Addendum: Self-reported by providers. Provider-level data on availability of services inclusive of data on total capacity, slots, available and total youth waiting.

"Waitlist F/U Report": Provider detail on the follow-up providers have with clients on the waiting list. Contractor gathers this detail through phone calls to providers and manually produces the report.

c. CSA Monthly Provider-level report and CSA waitlist follow-up report, Provider-specific. (due on the 30th of each month)

"CSA Monthly Provider Report": Self-reported by CSAs. Includes data on members being served, total # members waiting, waiting by # days, average length of time from request to start of service

"CSA Waitlist Follow-up Report": Self-reported by CSAs. Includes provider-level data on youth waiting for service for CSAs with waitlists inclusive of total # of youth waiting and youth who started the service at the time of the follow-up call from Contractor.

d. MCI Provider-level report on timeliness of encounter and location of Encounter.

"MCI Monthly Provider Report": Includes the # of encounters, average response time in minutes, and percentage of encounters with responses less than 30 minutes

20. CSA REPORTED AND AGGREGATED DATA – BH-N/A (MONTHLY)

CSA-reported data on referrals, discharges, enrollment and staffing, as described in CSA Operations Manual.

"MCI Referral to ED" : Provides source of referral to ED for MCI services as reported in the encounter data.

"IHT Response Time": Average time to first IHT appointment.

"CARD Report": A graph which represents the number of youth awaiting discharge from a BH acute hospital or diversionary level of care. Includes the number of youth awaiting discharge on the last day of each month of the fiscal year.

"Monthly Bed and Boarding Report": A chart which outlines the number of youth involved with Contractor awaiting inpatient hospital placement and the number of available inpatient beds.

"TCU Report": Count of the number of youth covered by Contractor who are in a Transitional Care Unit as of the last day of the month.

21. CBHC REPORTS – BH-N/A

CBHC Monitoring reports to be developed with the Contractor based on CBHC performance specifications, including on all services provided by CBHCs.

22. PROVIDER CONCERNS REPORT – BH-27

Report of all concerns reported by Network Providers stratified by PCC Network Providers and BH Network Providers.

"Provider Concern Report Month YYYY": Includes a summary about: whether the concern regards Contractor, the provider, or MassHealth; reason category and subcategory (quality of service, quality of care, access to care, billing/finance, or other issues); concern resolution type; an analysis of concerns; and management actions/next steps

23. PCC AND BH NETWORKS SITE VISIT REPORT – BH-29

Report of BH Network and PCC site visits, which includes but is not limited by the requirements of **Sections 2.8.H and 2.19.C**, respectively**.**

"Appendix E Report "PQM Site Visit Report

24. PCC PLAN MANAGEMENT SUPPORT SERVICES REPORT – BH-30

Report of PCC Plan Management Support deliverables.

"Month YYYY Plan Support Services Report": Comprehensive summary of the activities related to the PCC Plan Support Services Program including site visits, internal and external meetings, related data

25. CARE MANAGEMENT REPORT – BH-N/A

Report of all Care Management, Integrated Care Management and Practice-Based Care Management, which includes but is not limited to the requirements found **in Section 2.5.A-H** in a form and format to be determined by EOHHS and the Contractor.

"ICMP PBCM": Excel sheet detailing count and percentage

"ICMP PBCM Narrative": Details engagement, disenrollment, high-risk identification, noticeable changes, opportunities for improvement, interventions/next steps for ICMP and PBCM

26. CARE MANAGEMENT – PBCM REPORT

The Contractor shall calculate and report on the number of Participants in Practice Based Care Management on a monthly basis.

27. DATA GATHERING AND REPORTING CAPACITY IN THE MASSACHUSETTS BEHAVIORAL HEALTH ACCESS (MABHA) WEBSITE

Deliver to EOHHS and DMH: (1) a monthly progress report on the Contractor's progress toward implementing the efforts described in **Section 2.10.E.**

Quarterly Reports

28. TELEPHONE STATISTICS – BH-19

Report including a separate section for clinical calls and Provider and Covered Individual services calls that includes the number of calls, received, answered and abandoned, as well as the measures of Contract performance standards on calls answered within 30 seconds, and average speed of answer.

29. CANS COMPLIANCE: – BH-14

CANS Compliance. This report is required when CANS data is made available through the Virtual Gateway

"BH-14 CANSCompliance_by_LOC": Summary of members receiving outpatient/ICC/IHT in time frame, with CANS assessment marked with appropriate LOC, and compliance rate and summary of members receiving discharges for CBAT and inpatient, number of discharges with CANS assessment with appropriate LOC, and compliance

30. BEHAVIORAL HEALTH CLINICAL OPERATIONS/INPATIENT AND ACUTE SERVICE AUTHORIZATION, DIVERSIONS, MODIFICATION AND DENIAL REPORT – BH-13

Summary report on authorizations, diversions, modifications, and service denials of mental health inpatient services and substance use disorder acute services. In addition, summary report of number of:

- Covered Individuals enrolled in PACT;
- Covered Individuals enrolled in PACT who assessed psychiatric inpatient level of care;
- Covered Individuals enrolled in PACT who accessed Crisis Stabilization Services; and

31. BEHAVIORAL HEALTH CLINICAL OPERATIONS AND ACUTE SERVICE AUTHORIZATION, DIVERSIONS, MODIFICATION AND DENIAL REPORT (ABA) – BH-08

Summary report on ABA authorizations, diversions, modifications, and service denials.

"ABA Clinical Ops Data and Graphs"

"ABA Clinical Ops"

32. SUBSTANCE USE DISORDER CLINICAL OPS/INPATIENT AUTHORIZATION REPORT – BH-23

Substance Use Disorder Clinical Operations/Inpatient & Acute Service Authorization Modification and Denial Report

"BH SUD Clinical Ops Quarterly Q#_CYYYYY": Includes the number of notifications and continued stayed requests as well as the number of continued stay requests approved, modified, or denied. Timeliness is also reported

33. PHARMACY RELATED ACTIVITIES REPORT – BH-N/A

A report on pharmacy-related activities the Contractor has performed in support of the Contract, which includes but is not limited to the requirements found in **Section 2.6.D.**

"Pharmacy Related Activities Report CYYYYYQ#": Includes information by age groups on any BH med, on any AP med, on AP without a BH diagnosis, and polypharmacy

34. BEHAVIORAL HEALTH UTILIZATION AND COST REPORT – BH-15

A summary of Behavioral Health costs and utilization.

35. CLAIMS PROCESSING REPORT – BH-N/A

Behavioral Health Claims processed, paid, denied, and pending per month.

"Denied Claims": Summarizes all claim lines and claim dollars by denial reasons

"Pended Claims": Summarizes all claim lines and claim dollars by pend reasons

"Claims Activity": Summarizes claims received and paid/denied/pended, an analysis, and action items/next steps

"253A": Pie chart describing percentage of claims denied, paid, and pended every month

"253B": Pie chart describing percentage of claims denied, paid, and pended for the year

"253C": Pie chart describing percentage of claims denied, paid, and pended from 2023

36. BH PROVIDER NETWORK ACCESS AND AVAILABILITY REPORTS: – BH-18

a. Summary of significant changes in the Provider Network (including, but not limited to: changes in MassHealth Covered Services; enrollment of a new population in the Contractor's plan; changes in benefits; changes in Network Provider payment methodology).

b. BH Network geographic access.

c. Use of Out-of-Network Providers.

d. Appointment time availability standards.

e. Secret shopper report

Through these five reports, the Contractor must demonstrate that it 1) maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Covered Individuals in each of the State's regions; and 2) offers an appropriate range of specialty services that is adequate for the anticipated number of Covered Individuals in each of the State's regions.

"7175 BH Practitioners": Includes 7 provider maps, access summaries by city, and access details by city. Psychiatrists, psychologists, LCSW, LMFT, licensed mental health counselors, and registered nurse clinical nurse specialists.

"Geo Access Report": Summarizes geo-access standards for inpatient and outpatient services and whether or not they are incompliance with those standards

"7174 BH Facilities": Includes 3 provider maps, access summaries by city, and access details by city. Inpatient, outpatient, and group

"3556_BH_ORA": Provider and service changes for the PCC plan, ACO, and Managed Behavioral Health Plan

"Provider Changes": Additions, deletions, and changes to the Provider Network within the previous quarters with a focus on practitioners and facilities

"Use of Out of Network Providers Report": OON providers who provided services to Covered Individuals for BH Services and are located out-of-state and those who provided services to Covered Individuals due to linguistic/cultural needs, geographic issues, and specialty needs

37. QUARTERLY FRAUD AND ABUSE REPORT – CM-19

38. QUARTERLY SUMMARY OF PROVIDER OVERPAYMENT – CM-35

39. QUARTERLY PROGRAM INTEGRITY COMPLIANCE PLAN, AND ANTI-FRAUD, WASTE AND ABUSE PLAN – CM-51

40. EC - MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT REPORT – BH-N/A

Report of early childhood BH Encounters by MCPAP Providers statewide stratified by months and year to date **(Section 2.6.D.2.f-j).**

41. QUARTERLY MCPAP PROGRAM UTILIZATION, STRATIFIED BY MONTH

Other program utilization data elements that may be identified by EOHHS and DPH.

"MCPAP Activity 3Yr Trending": Includes aggregate counts, activity by team (BH advocacy, face-to-face, phone, practice education, and resource-referral), and activity for ASDID for MCPAP team.

"MCPAP Utilization Report with ASD": Includes utilization summaries by region, by region and practice, and by practice and provider type for ASD.

42. MCPAP AVERAGE ENCOUNTER

Average number of encounters per unduplicated Covered Individuals by month, by ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team.

43. MCPAP QUARTERLY ENCOUNTER

For each ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team: number of encounters by type of encounter by month, diagnosis, reason for contact, and insurance status of the child. For ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team, must include location of individual (e.g., home, school, emergency department, community-based behavioral health provider), the email address of the individual/ family, name of the AMCI/YMCI Team or ED seeking consult, and patient demographic data including race, ethnicity, and primary language. Quarterly and annual reports should show quarterly trends in number of encounters by type of encounter for three years.

44. MCPAP QUARTERLY UNDUPLICATED COUNT

For each ASD-ID for MCPAP Team (i.e., Boston North, Boston South, and Central/West), Site/Institution, and statewide ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team: unduplicated monthly count of Covered Individuals served, by type of encounter and insurance status of the Covered Individual. Quarterly and annual reports should show quarterly trends in number of Covered Individuals served for three years.

45. MCPAP QUARTERLY RESPONSE TIME

For each ASD-ID Behavioral Team and ASD-ID Statewide Physician Consult Team, percentage of providers that receive advice within 30 minutes of their contact (for those providers that do not request call back later than 30 minutes) stratified by month.

46. MCPAP AND ASD-ID APPOINTMENT AVAILABILITY

For each ASD-ID team, the wait time for the first and next available appointments for face-to-face assessment with a MCPAP psychiatrist or with a MCPAP Behavioral Health clinician, stratified by month. If an ASD-ID team fails to meet one or both of the wait time standards described in **Section 2.6.D.2.e.** for three consecutive months, the Contractor shall

submit a report detailing the reasons why they are unable to meet the standards. The report must describe the number of face to face visits completed by each institution, reason for assessments, and the age, gender, diagnoses, and insurance coverage of children receiving the assessments.

47. EC-MCPAP AND ASD-ID OUTREACH AND TRAINING

The number of outreach and training activities for MCPAP providers including:

1. Number and type of outreach and training activities conducted by ASD-ID for AMCI/YMCI teams and EDs as in **Section 2.6.D.2.f.6**. Number, if known, of individuals reached. Number of public awareness activities conducted by ASD-ID for families of individuals with ASD/IDD, pediatric providers, staff at Autism Support Centers, and parent resource groups, or other stakeholders on topics described in **Section 2.6.D.2.f.7.** Number, if known, of individuals reached.
2. Number and type of outreach and training activities conducted for EC-MCPAP

48. PHARMACY QUARTERLY ACTIVITIES REPORT

The pharmacy director's quarterly activities report to EOHHS on pharmacy-related activities as described in **Section 2.6.D.1.a.6.**

49. CSA REPORTED AND AGGREGATED DATA (QUARTERLY)

"**IHT Key Indicator**": Includes the percentage of enrollees who use TT&S, percentage of enrollees who receive services from a MA clinician, percentage of enrollees using other LOC, and average units billed per month

"**IHBS Key Indicator**": Includes the total youths enrolled by age group, enrollment by Hub type, number of enrollees receiving services by either a MA or BA-level clinician. Point-in-time data.

"**TM Key Indicator**": Includes the total youth enrolled by age group and enrollment by Hub type. There are three different versions of the report based on provider enrollment size.

"**MCI Key Indicator**"**- Statewide**: Displays data on the number of distinct MCI encounters, the number of encounters occurring in the community, average response times, and the percent of MCI encounters resulting in an inpatient admission.

"**MCI Key Indicator**"**- Provider Level**: Displays data by provider-level on the number of distinct MCI encounters, the number of encounters occurring in the community, average response times, and the percent of MCI encounters resulting in an inpatient admission.

Semi-Annual Reports

51. BOH APPEALS REPORT – BH-N/A

A report that includes but is not limited to, for each category of Adverse Action, the number, nature, resolution and time frame for resolution of BOH Appeals, stratified by level of Appeal, Region, and Level of Care.

52. GRIEVANCE AND INTERNAL APPEALS REPORT – BH-22

A report on the number of Grievances and Internal Appeals, including the type of Grievance or Internal Appeal, type of resolution, and the timeframe for resolution. Includes analysis and next steps.

53. COORDINATION OF BENEFITS/THIRD-PARTY LIABILITY REPORT – BH-N/A

a. Third-party health insurance cost avoidance Claims amount, by carrier

b. Third-party health insurance total recovery savings, by carrier.

"Coordination of Benefits": Contractor's actual savings via Third Party Insurance Benefit Coordination and the actual cost of avoidance via the denial of claims

"TPLSAV": Savings amounts per month

"353_ORA": Historical list of savings

"4669_ORA": Quarterly report of total claim lines and total claimed

"5630_ORA": Monthly payment timeliness report including total claims, average days for payment, SD days for payment, and #/% claims paid within 30 days

54. CSA REPORTED AND AGGREGATED DATA

"Wraparound Fidelity Index": Set of four interviews that measure the nature of the wraparound process that an individual family receives to measure fidelity to principles.

"Team Observation Measure": Observation of care planning team meetings by supervisors to assess adherence to standards of high-quality wraparound.

Annual Reports

56. NETWORK MANAGEMENT STRATEGIES REPORT – BH-N/A

A summary description of the Contractor's network management strategies and activities related to access, appropriateness of care, continuity of care, cost efficiency, and treatment outcomes; including an analysis of the effectiveness of the Contractor's strategies and activities; and the Contractor's plans for implementing new strategies or activities.

57. BEHAVIORAL HEALTH ADVERSE INCIDENT SUMMARY REPORT – BH-02

Summary report of Reportable Adverse Incidents. Incidents are categorized by sentinel, major, moderate, and minimal. Report includes graphs and an analysis of the incidents along with action items/next steps.

58. BEHAVIORAL HEALTH AMBULATORY CONTINUING CARE RATE – BH-04

Report of Outpatient Services or non-24-hour Diversionary Services a Covered Individual receives after being discharged from a 24-hour Level of Care service.

59. BEHAVIORAL HEALTH READMISSION RATES REPORT – BH-03

Report of the number and rate of readmissions to 24-hour Level of Care within 7, 30, 60 and 90 days of discharge from a 24-hour Level of Care setting, stratified by type of service, DMH involvement, PCC Plan enrollment, and age.

60. BEHAVIORAL HEALTH URGENT CARE PROGRAM – ANNUAL REPORT

Annual analysis and summary of the Behavioral Health Urgent Care Member Experience Survey.

61. PAY FOR PERFORMANCE INCENTIVE REPORTING – BH-N/A

Report on selected Pay-for-Performance measures, as defined in **Appendix G**.

62. SATISFACTION SURVEY SUMMARY – BH-32

Periodic reports as described in **Section 2.13.F.5.d-f** due within 60 calendar days following the end of the survey period, the results and analysis of the findings report of satisfaction survey conducted with Network Providers, PCCs, and Covered Individuals.

63. MEDICAL RECORDS REVIEW REPORT – BH-11

Report that includes requirements found in **Section 2.14.K** as will be developed by EOHHS and Contractor.

64. PCC PLAN MANAGEMENT SUPPORT SERVICES REPORT – BH-33

Summary report of PMSS activities and integration efforts for the previous Contract Year that includes efforts to enhance integration and PCC health delivery, goals, and results as required by but not limited to **Section 2.19A.**

65. PCC COMPLIANCE WITH PCC PROVIDER AGREEMENT – BH-34

Report of PCCs' compliance with the PCC Provider Agreement as required by but not limited to **Section 2.19.B.**

66. PROVIDER PREVENTABLE CONDITIONS – BH-N/A

Report on Provider Preventable Conditions as required in **Section 2.15.E.**

67. QUALITY MANAGEMENT PLAN FOR BH MANAGEMENT

The Contractor must submit a single plan, on an annual basis, that defines the quality management program, details the Contractor's quality activities, and provides for self-assessment of the Contractor's responsibilities under the Contract, as required by **Section 2.13.F**.

68. QUALITY MANAGEMENT PLAN FOR PCC PLAN MANAGEMENT SUPPORT SERVICES

The Contractor must submit a single plan, on an annual basis, that reflects the Contractor's organizational QM philosophy and structure and includes PCC Plan Management Support Services-related activities, as required in **Section 2.13.G.1**.

69. NETWORK PROVIDER SATISFACTION SURVEY

Assessment and analysis of Network Provider satisfaction with the Contractor's administration and management of the BHP and Care Management Program stratified by Provider type and specialty, at least biennially as required in **Section 2.13.F.5**.

70. PCC PROVIDER SATISFACTION SURVEY

Assessment and analysis of PCC satisfaction with the Contractor's administration and management of the BHP, PCC Plan Management Support Services, and the Care

Management Program stratified by Provider type and specialty, at least biennially as required in **Section 2.13.F.5**.

71. COVERED INDIVIDUAL SATISFACTION SURVEY

Assessment and analysis of Covered Individual's satisfaction with the Contractor, at least biennially as required in **Section 2.13.F.5**.

72. MOBILE CRISIS INTERVENTION/RUNAWAY ASSISTANCE PROGRAM (MCI/RAP) OUTCOME AND OUTPUT MEASURES REPORT- BH-N/A

An annual summary report on outcomes and outputs related to the MCI/RAP which includes but is not limited to the requirements found in **Section 2.7.I.5.**

73. PCC PLAN MANAGEMENT SUPPORT SERVICES TRAINING – BH-35

Summary of activities related to the approved plan for training and enhancing staff performance on all functions associated with the PCC Plan Management Support Services; and the results of training on staff performance.

74. MCPAP TEAMS

Composition of MCPAP Teams for ASD-ID for MCPAP including staffing and their FTEs (Full Time Equivalents).

"FTE YYYY"

75. MCPAP ANNUAL ENCOUNTERS

For ASD-ID for MCPAP Behavioral Team and Statewide Team: number of encounters by type of encounter, diagnosis, reason for contact, and insurance status of the child. For ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team, must include location of individual (e.g., home, school, emergency department, community-based behavioral health provider), the email address of the individual/ family, name of the AMCI/YMCI Team or ED seeking consult, and patient demographic data including race, ethnicity, and primary language. Quarterly and annual reports should show quarterly trends in number of encounters by type of encounter for three years.

MCPAP Encounter Report"

76. MCPAP ANNUAL UNDUPLICATED COUNT

For ASD-ID for MCPAP Behavioral Team and Statewide Team: unduplicated count of Covered Individuals served, by type of encounter and insurance status of the Covered Individual. Quarterly and annual reports should show quarterly trends in number of Covered Individuals served for three years.

"MCPAP FYXXQX Insurance Report"

"MCPAP Unduplicated Mbrs 3Yr Trending": Chart showing unduplicated members served overall and by team

77. ASD-ID FOR MCPAP CHILDREN CONSULTATION

For each ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team, the number of children and young adults whom AMCI/YMCI teams or EDs request consultation for at least two or more times during the contract year (i.e., episodes of care). This episode

report must describe the demographics of the patient (e.g., age, gender, diagnoses, insurance, race, ethnicity, primary language, etc.), type and average number of encounters provided to AMCI/YMCI or ED and family (if relevant), reasons for consultation, type of intervention advised/ provided, and outcome of consultation.

78. MCPAP ANNUAL PROVIDER EXPERIENCE SURVEY

Results of annual Provider Experience Surveys for ASD-ID for MCPAP.

79. COMMUNITY SUPPORT PROGRAM – CHRONICALLY HOMELESS INDIVIDUALS (CSP-CHI)

Provide annually the Community Support Program – Chronically Homeless Individuals (CSP-CHI) report as specified by EOHHS.

80. COMMUNITY SUPPORT PROGRAM – TENANCY PRESERVATION PROGRAM (CSP-TPP)

Provide annually the Community Support Program – Tenancy Preservation Program (CSP-TPP) report as specified by EOHHS.

81. MATERIAL SUBCONTRACTORS

Submit annually to EOHHS a list of all Material Subcontractors. Such annual report shall include notification if any of its Material Subcontractors are certified Minority Business Enterprises. The Contractor shall submit an updated list at least 30 days in advance of any changes to the list or as otherwise directed by EOHHS

82. CBHC ADMINISTRATIVE OVERSIGHT

The Contractor shall develop an annual report that tracks utilization of Massachusetts Behavioral Health Access System and other data as agreed to by other parties.

83. CSA REPORTED AND AGGREGATED DATA

"Wraparound Fidelity Index": Set of four interviews that measure the nature of the wraparound process that an individual family receives to measure fidelity to principles**.**

"Team Observation Measure": Observation of care planning team meetings by supervisors to assess adherence to standards of high-quality wraparound**.**

84. QUALITY MANAGEMENT FOR PCC PLAN MANAGEMENT SUPPORT SERVICES

The Contractor shall create and implement a single, comprehensive Quality Management plan, and this plan should include an annual retrospective QM activities report based on the previous year's QM plan, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year.