

Three-Way Contract for Capitated Model

Contract

Between

**United States Department of Health and Human Services
Centers for Medicare & Medicaid Services**

In Partnership with

The Commonwealth of Massachusetts

and

**Commonwealth Care Alliance, Inc.
Tufts Health Public Plans, Inc.**

Issued

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This Contract, effective July 16, 2013, and amended by addendum effective September 10, 2014 and January 7, 2015, is hereby amended and restated effective December 28, 2015, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (EOHHS) and _____ (the Contractor). The Contractor's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible, in relevant part, for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, the Massachusetts Executive Office of Health and Human Services is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et. seq., and M.G.L. c. 118E, designed to pay for medical services for eligible individuals;

WHEREAS, the Contractor is in the business of providing medical services, and CMS and the Massachusetts Executive Office of Health and Human Services desire to purchase such services from the Contractor;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

Section 1. Definition of Terms

Actual Non-Service Expenditures — The Contractor’s actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during Demonstration Year 1. These costs will exclude start-up costs, defined as costs incurred by the Contractor prior to the start of the Demonstration. Any reinsurance costs reflected here will be net reinsurance costs.

Actual Service Expenditures — The Contractor’s actual amount paid for Covered Services (as defined in **Appendix A**) delivered during Demonstration Year 1. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.

Adjusted Capitation Rate Revenue — The Total Capitation Rate Revenue excluding the monthly capitation payments for Medicare Part D services and any risk adjustment or reconciliation associated with Medicare Part D payments.

Adjusted Non-Service Expenditures — The Contractor’s Actual Non-Service Expenditures, adjusted to reflect the following:

- Exclusion of any costs, including care management, associated with Medicare Part D services as identified in CMS bid instructions and other guidance;
- Exclusion of costs greater than 125% of the median cost per member per month across all participating Contractors during Demonstration Year 1. Consideration will be given to any Contractor with significant non-typical membership mixes that may cause this exclusion to come into effect; and
- Exclusion of reinsurance costs (net of reinsurance premiums); and
- Adjustments resulting from CMS and EOHHS review of the Contractor’s non-service expenditures to address any excessive non-service expenditures (including executive compensation and stop loss expenditures).

Adjusted Service Expenditures — The Contractor’s Actual Service Expenditures, adjusted to reflect the following:

- Exclusion of the cost of all services provided under Medicare Part D;
- Reductions to reflect any recoveries from other payors outside of claims adjudication, including those pursuant to coordination of benefits, third party

liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in **Section 4.3.B**). These adjustments shall exclude any adjustments associated with coverage of Medicare Part D services; and

- Adjustments resulting from CMS and EOHHS review of Contractor reimbursement methodologies and levels to address any excessive pricing.

Adverse Action — Any one of the following actions or inactions by the Contractor:

- the failure to provide Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.9**;
- the denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;
- the reduction, suspension, or termination of a previous authorization by the Contractor for a service;
- the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:
 - failure to follow prior authorization procedures;
 - failure to follow referral rules;
 - failure to file a timely claim;
- the failure to act within the timeframes in **Section 2.9.D.7** for making authorization decisions; and
- the failure to act within the timeframes in **Section 2.12.B** for reviewing an internal Appeal and issuing a decision.

Alternative Formats — Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative.

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

Appeal – An Enrollee’s request for formal review of an Adverse Action of the Contractor in accordance with **Section 2.12**.

Behavioral Health Clinical Assessment— The comprehensive clinical assessment of an Enrollee that includes a full bio-psycho social and diagnostic evaluation that informs behavioral health treatment planning. A Behavioral Health Clinical Assessment is performed when an Enrollee begins behavioral health treatment and is reviewed and updated during the course of treatment.

Behavioral Health Providers— Providers of mental health and substance use disorder services that are Covered Services.

Behavioral Health Services – Mental health and substance use disorder services that are Covered Services.

Benefit Coordination – The function of coordinating benefit payments from other payers, for services delivered to an Enrollee, when such Enrollee is covered by another coverage source.

Capitated Financial Alignment Model (“the Demonstration”) – A model where a State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.

Capitation Rate – The sum of the monthly capitation payments for Demonstration Year 1 (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to **Appendix A** and **B** of this Contract) including: 1) the application of risk adjustment methodologies, as described in **Section 4.2.D**; 2) any payment adjustments as a result of the reconciliation described in **Section 4.5**; and 3) any payments as a result of the High-Cost Risk Pool, as described in **Section 4.2.E**. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

Care Coordinator – A clinician or other trained individual employed or contracted by the Primary Care Provider or the Contractor who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the Comprehensive Assessment; and supporting safe transitions in care for Enrollees moving between settings. See **Section 2.5.C.2** for more information about the requirements, qualifications, and responsibilities of a Care Coordinator.

Centers for Medicare & Medicaid Services (CMS) – The federal agency under the Department of Health and Human Services responsible for administering, in relevant part, the Medicare and Medicaid programs.

Centralized Enrollee Record – Centralized and comprehensive documentation, containing information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions. See **Section 2.6.E.2** for more information about the contents of the Centralized Enrollee Record.

Clinical Care Management – A set of services provided by a Clinical Care Manager that comprise intensive monitoring, follow-up, care coordination, and clinical management of individuals with Complex Care Needs.

Clinical Care Manager – A licensed registered nurse or other individual licensed and/or certified to provide Clinical Care Management, and will serve as the Care Coordinator for individuals with Complex Care Needs.

Clinical Criteria – Criteria used to determine the most clinically appropriate and necessary level of care and intensity of services to ensure the provision of Medically Necessary Services.

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

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

Complaint – Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the Contractor’s or provider’s operations, activities, or behavior, regardless of whether remedial action is requested. 42 C.F.R. § 422.561. Possible subjects for Complaints include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of Contractor, or failure to respect the Enrollee’s rights.

Complex Care Need – Enrollees who are determined to have significant health care needs and require intensive care coordination services/activities geared towards addressing their physical, behavioral health and/or social care needs. These Enrollees typically have co-morbidities and psychosocial needs that if not addressed can significantly diminish their quality of life as well as their ability to adhere to treatment plans. Care Coordination services for these Enrollees are typically provided by a licensed registered nurse or other individuals licensed to provide Clinical Care Management, as these Enrollees typically require very

individualized services tailored to their needs and stage of readiness with a goal of averting the need for more intensive medical services.

Comprehensive Assessment – An assessment conducted using a Contractor-developed assessment tool that is informed by at least one in-person meeting and includes all domains as described in **Section 2.6.A.3**, as may be relevant for each Enrollee to the creation of his or her Individualized Care Plan.

Consumer – An Enrollee or Potential Enrollee, or the spouse, sibling, child, or unpaid primary caregiver of an Enrollee or Potential Enrollee.

Continuing Services – Covered Services that were previously authorized by the Contractor and are the subject of an internal Appeal or Board of Hearings (BOH) Appeal, if applicable, involving a decision by the Contractor to terminate, suspend, or reduce the previous authorization and which are provided by the Contractor pending the resolution of the internal Appeal or BOH Appeal, if applicable.

Contract – This participation agreement that CMS and EOHHS have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.

Contract Management Team – A group of CMS and EOHHS representatives responsible for overseeing the contract management functions outlined in **Section 3.1.A** of the Contract.

Contract Operational Start Date – The first date on which any enrollment into the Contractor's Integrated Care Organization is effective.

Contractor – An entity approved by CMS and EOHHS that enters into a Contract with CMS and EOHHS in accordance with and to meet the purposes specified in this Contract.

Covered Services – The set of services to be offered by the Contractor.

Demonstration – See Capitated Financial Alignment Model.

Demonstration Year – Demonstration Year 1 runs from the first Effective Enrollment Date through December 31, 2014; Demonstration Year 2 runs from January 1, 2015 through December 31, 2015; and Demonstration Year 3 runs from January 1, 2016 through December 31, 2016.

Effective Enrollment Date – The first calendar day of the month following receipt of Enrollee’s enrollment into an ICO by EOHHS or CMS, or their designee.

Eligible Beneficiary – For the purpose of this contract, and as laid out in Section III.C.1 of the Memorandum of Understanding between CMS and the Commonwealth of Massachusetts dated August 22, 2012 (MOU), a Consumer who is eligible to enroll in the Demonstration but has not yet done so. This includes individuals who are enrolled in Medicare Part A and B and eligible for and receiving MassHealth Standard or CommonHealth, have no other comprehensive private or public health coverage, and who meet all other Demonstration eligibility criteria.

Emergency Condition – A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services – Inpatient and outpatient services covered under this Contract that are furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee’s Emergency Condition. Emergency Services include Post-stabilization Services provided after an emergency is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee’s condition.

Emergency Services Program (ESP) – Services provided through designated, contracted providers which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health

crisis. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization.

Enrollee – Any Medicare-Medicaid eligible individual who is enrolled with a Contractor.

Enrollee Communications – Materials designed to communicate plan benefits, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

Enrollee Service Representative (ESR) – An employee of the Contractor who assists Enrollees with questions and concerns.

Enrollees with Special Health Care Needs – Enrollees including, at a minimum, those who have or are at increased risk to have chronic physical, developmental, or behavioral health condition(s); require an amount or type of services beyond those typically required for individuals of similar age; and may receive these services from an array of public and/or private providers across health, education and social systems of care.

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

Federally-Qualified Health Center (FQHC) – An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(1)(2)(B).

First Tier, Downstream and Related Entity – An individual or entity that enters into a written arrangement with the Contractor, acceptable to CMS, to provide administrative functions or Covered Services of the Contractor under this Contract.

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

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

Grievance – Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. 422.566, expressing dissatisfaction with any aspect of the Contractor's or provider's operations, activities, or behavior, regardless of whether remedial action is requested (pursuant to 42 C.F.R. § 422.561). 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 Primary Care Provider or employee of Contractor, or failure to respect the Enrollee's rights (as provided for in 42 C.F.R. § 438.400).

Health Care Acquired Conditions (HCACs) — Conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886 (d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT/pulmonary embolism (PE)) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Healthcare Effectiveness Data and Information Set (HEDIS) – Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Health Outcomes Survey (HOS) – Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

Health Plan Management System (HPMS) – A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

Independent Living and Long-Term Services and Supports (IL-LTSS) Coordinator – A coordinator contracted by the Contractor from a community-based organization (CBO) to ensure that an independent resource is assigned to and available to the Enrollee to perform the responsibilities described in Section 2.5.C.4., including assisting with the coordination of his/her LTSS needs and providing expertise on community supports to the Enrollee and his/her care team.

Independent Living Philosophy – A philosophy which advocates for the availability of a wide range of services and options for maximizing self-reliance and self-determination in all of life's activities.

Indian Enrollee – An Enrollee who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

Indian Health Care Provider – A health care program or provider, operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)

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

Integrated Care Organization (ICO) – A health plan or provider-based organization contracted to provide and accountable for providing integrated care to Enrollees. All Contractors participating in the Demonstration shall be designated as One Care plans (also known as ICOs). See also One Care plan.

Interdisciplinary Care Team (ICT) – A team of Primary Care Provider, Care Coordinator, Independent Living and Long-Term Services and Supports Coordinator and other individuals at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the Individualized Care Plan.

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

Marketing, Outreach, and Enrollee Communications – Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 C.F.R. 422.2260.

MassHealth – The medical assistance and benefit programs administered by the Massachusetts Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act, Section 1115 demonstration, M.G.L. c. 118E, and other applicable laws and regulations (Medicaid).

Medically Necessary Services – Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and MassHealth. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Medicaid law and regulations, and per MassHealth, services must be:

- Provided in accordance with MassHealth regulations at 130 CMR 450.204,
- Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life,

- cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
- For which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary Services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Medicare-Medicaid Coordination Office – Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

Medicare-Medicaid Beneficiary – For the purposes of this Demonstration, individuals who are enrolled in Medicare Part A and B and eligible for and receiving MassHealth Standard or CommonHealth and no other comprehensive private or public health coverage.

Medicaid – The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof.

Medicare – Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

Medicare Advantage – The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.

Minimum Data Set (MDS) – A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for nursing facility residents.

Minimum Data Set-Home Care (MDS-HC) – A clinical screening system using proprietary tools developed by interRAI Corporation, which assesses the key domains of function, health, and service use.

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

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

Ombudsperson — A neutral and conflict-free person or entity that provides assistance to plan members with access, billing and service issues. The Ombudsperson provides information on the plan Grievance and Appeal guidelines and can guide the Enrollee through that process. He or she can also perform mediation between the Enrollee and the ICO.

One Care Plan — A health plan or provider-based organization contracted to provide and accountable for providing integrated care to Enrollees. All Contractors participating in the Demonstration shall be designated as One Care plans (also known as ICOs). See also Integrated Care Organization (ICO).

Other Provider Preventable Conditions (OPPC) — A condition that meets the requirements of an “Other Provider Preventable Condition” pursuant to 42

C.F.R. 447.26(b). OPPCS may occur in any health care setting and are divided into two sub-categories:

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

For each of a through c above, the term “surgical or other invasive procedure” is defined in CMS Medicare guidance on NCDs.

2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are State-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as Additional OPPCs.

Passive Enrollment – An enrollment process through which an eligible individual is enrolled by the EOHHS (or its vendor) into a Contractor’s plan following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision prior to the effective date.

Personal Care Assistant (PCA) – A person who provides personal care to an Enrollee who requires assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Personal Assistance Services (PAS Services) – Physical assistance, cueing, and/or monitoring with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided to an Enrollee by a PCA in accordance with the Enrollee’s Individualized Care Plan.

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

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

Post-stabilization Services – Covered Services, related to an Emergency Condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, and for which the Contractor is responsible when 1) the services are authorized; 2) the services are provided to maintain the Enrollee’s stabilized condition within one hour of a request to the Contractor for service authorization of further Post-stabilization Services; 3) the Contractor could not be contacted; 4) the Contractor did not respond to a service authorization request within one hour; or 5) the Contractor and treating provider are unable to reach agreement regarding the Enrollee’s care.

Prevalent Languages – English, Spanish and any languages spoken by 5% or more of Enrollees in the Service Area.

Primary Care Provider (PCP) – A practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the ICO and responsible for providing and coordinating the Enrollee’s health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be nurse practitioners, physician assistants or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, OB/GYN, or geriatrics.

Privacy – Requirements established in the Health Insurance Portability and Accountability Act of 1996 and Privacy Act of 1974 (HIPAA), and implementing regulations, as well as relevant Massachusetts Privacy laws.

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

Provider Network – A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers, mental health/substance abuse providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. (See **Appendix D** of the Contract.)

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

Rating Categories (RCs) – The categories used by the MassHealth component of the capitation payment methodology, as described in **Section 4.2.A**.

Readiness Review – Prior to being eligible to accept Demonstration enrollments, each prospective Contractor selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor’s ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Services. CMS and the EOHHS use the results to inform its decision of whether the prospective Contractor is ready to participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and potentially a site visit to the prospective Contractor’s headquarters.

Risk Corridor Percentage – For each Demonstration Year, the Contractor’s Total Adjusted Expenditures divided by the Adjusted Capitation Rate Revenue for the applicable Demonstration Year, rounded to the nearest one tenth of a percent.

Self-directed PCA – A model of service delivery in which the Enrollee, or the Enrollee’s designated surrogate, is the employer of record, and has decision-making authority to hire, manage, schedule, and dismiss their PCA worker(s).

Serious Reportable Event (SRE) – An event that occurs on premises covered by a hospital’s license that results in an adverse patient outcome, is clearly identifiable and measurable, usually or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital. An SRE is an event that is specified as such by the Department of Public Health (DPH) and identified by EOHHS.

Service Agreement – A written plan of services developed in conjunction with the Enrollee, as appropriate, that describes the responsibilities of parties as they relate to the management of the Enrollee’s Self-directed PCA Services.

Service Area – The specific geographical area of Massachusetts designated in the CMS HPMS, and as referenced in **Appendix K**, for which the Contractor agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the Contractor.

State – The Commonwealth of Massachusetts.

State Fair Hearing – An Appeal filed for Medicaid services with the State Board of Hearings.

Third Party Liability (TPL) Indicator Form – Form supplied to inpatient hospitals by EOHHS that is used to notify the Contractor when the hospital discovers that an

Enrollee has comprehensive insurance coverage other than Medicare or Medicaid.

Total Capitation Rate Revenue – The sum of the monthly capitation payments for Demonstration Year 1 (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medicaid services, pursuant to **Appendix A** of this contract) including: 1) the application of risk adjustment methodologies, as described in **Section 4.2.D**; 2) any payment adjustments as a result of the reconciliation described in **Section 4.5**; and 3) any payments as a result of the High-Cost Risk Pool, as described in **Section 4.2.E**. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

Total Adjusted Expenditures – The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.

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

Section 2. Contractor Responsibilities

Through the Capitated Financial Alignment Model initiative, CMS and EOHHS will work in partnership to offer Medicare-Medicaid Beneficiaries the option of enrolling in Contractor's participating plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and MassHealth Covered Services for Enrollees.

2.1 Compliance

The Contractor must, to the satisfaction of CMS and EOHHS:

- A. Comply with all provisions set forth in this Contract; and
- B. Comply with all applicable provisions of federal and State laws, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that variances from these requirements are provided in the MOU signed by CMS and EOHHS for this initiative.
- C. The Contractor agrees that it will develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. 455.
- D. Comply with all aspects of the joint Readiness Review.
- E. Comply with all applicable administrative bulletins issued by EOHHS.

2.2 Contract Management and Readiness Review Requirements

A. Contract Readiness Review Requirements

1. CMS and EOHHS, or their designee, will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2. CMS and EOHHS Readiness Review Responsibilities
 - a. CMS and EOHHS or their designee will conduct a Readiness Review of each Contractor that will include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of Medicare-Medicaid Beneficiaries into the Contractor's Plan. CMS and EOHHS or their designee 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.

 - b. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:
 - (1) Network Provider composition and access, in accordance with **Section 2.7**;
 - (2) Staffing, including Key Personnel and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with **Sections 2.10 and 5.3**;
 - (3) Capabilities of First Tier, Downstream and Related Entities, in accordance with **Appendix D**;
 - (4) Care Coordination capabilities, in accordance with **Section 2.5.C**;
 - (5) Content of Provider Contracts, including any Provider Performance Incentives, in accordance with **Sections 2.7 and 5.1.G**;
 - (6) Enrollee Services capabilities (materials, processes and infrastructure, e.g., call center capabilities), in accordance with **Section 2.10**;

- (7) Comprehensiveness of quality management/quality improvement and Utilization Management strategies, in accordance with **Section 2.13**;
- (8) Internal Grievance and Appeal policies and procedures, in accordance with **Section 2.1 and Section 2.12**;
- (9) Fraud and Abuse and program integrity policies and procedures, in accordance with **Section 2.8**;
- (10) Financial solvency, in accordance with **Section 2.15**;
- (11) Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with **Section 2.17**, including IT testing and security assurances.

c. No individual shall be enrolled into the Contractor's ICO unless and until CMS and the Commonwealth determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

d. CMS and EOHHS or their designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all identified deficiencies prior to the Contract Operational Start Date.

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

3. Contractor Readiness Review Responsibilities

- a. The Contractor must demonstrate to CMS and EOHHS's satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational

Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

- b. Provide CMS and EOHHS or their designee with corrections requested by the Readiness Review report within ten business days after receipt of the Readiness Review report.

B. Organizational Structure and Philosophy

The Contractor shall maintain an organizational statement that describes the Contractor's philosophy, operating history, location, organizational structure, ownership structure, and plans for future growth and development.

1. Contract Management Philosophy

- a. The Contractor shall develop and implement policies and procedures to ensure that all Medically Necessary Services are provided to Enrollees based on their individual needs and consistent with **Appendix A** and **B**. Such policies and procedures, including any updates to existing policies and procedures, shall be submitted to the Commonwealth for review upon request.
- b. The Contractor shall manage all aspects of its ICO line of business consistent with a data driven management philosophy, where decisions are made utilizing available data. Such data shall come from multiple sources including, claims and encounter data, authorization data, medical record reviews, Enrollee input, Provider surveys, clinical outcomes data, Appeals, Grievances, sanctions and corrective action plans. The Contractor shall use data analysis and reports for management purposes for Network Management, Utilization Management, Care Management, Quality Management, and customer service responsibilities under this Contract.

C. Contract Management

The Contractor must employ a qualified individual to serve as the contract manager of its Capitated Financial Alignment Model. The contract manager must be primarily dedicated to the Contractor's program and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program. The contract manager must act as liaison between the Contractor, CMS, and EOHHS, and has responsibilities that include but, are not limited to, the following:

1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the Request for Responses (RFR) and approved by CMS and EOHHS;
3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the Contractor's quality management director, medical director, and behavioral health clinician;
4. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least 30 days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network;
5. Receive and respond to all inquiries and requests made by CMS and EOHHS in time frames and formats specified by CMS and EOHHS;
6. Meet with representatives of CMS or EOHHS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;
7. Ensure the availability to CMS and EOHHS, upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, utilization management, Provider Network Management, and Benefit Coordination;
8. Attend and participate in regular director meetings with CMS and EOHHS;
9. Coordinate requests and activities among the Contractor, all subcontractors, CMS, and EOHHS;
10. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or EOHHS; and
11. Meet with CMS and EOHHS at the time and place requested by CMS and the Commonwealth if either CMS or EOHHS, or both, determine that the Contractor is not in compliance with the requirements of the Contract.

D. Organizational Structure

1. The Contractor shall establish, maintain and describe the interdepartmental structures and processes to support the operation and management of its ICO line of business in a manner that fosters integration of physical and behavioral health service provision. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available. The Contractor's Behavioral Health Services and activities should be person-centered, and oriented to recovery and rehabilitation from behavioral health conditions.
2. On an annual basis, and on an ad hoc basis when changes occur or as directed by EOHHS, the Contractor shall submit to EOHHS an overall organizational chart that includes senior and mid-level managers for the organization. The organizational chart must include the organizational staffing for Behavioral Health Services and activities. If such Behavioral Health Services and activities are provided by a First Tier, Downstream or Related Entity the Contractor shall submit the organizational chart of the behavioral health First Tier, Downstream or Related Entity which clearly demonstrates the relationship with the First Tier, Downstream or Related Entity and the Contractor's oversight of the First Tier, Downstream or Related Entity. For all organizational charts, the Contractor shall indicate any staff vacancies and provide a timeline for when such vacancies are anticipated to be filled.
3. For all employees, by functional area, the Contractor shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to EOHHS upon request.
4. For key management positions, including the Contractor's chief executive officer, if applicable, One Care plan executive director, chief medical officer/medical director, pharmacy director, behavioral health clinical director, director of long term services and supports, ADA compliance director, chief financial officer, chief operating officer, senior manager of clinical services, quality manager, claims director, information technology (IT) director, compliance officer, and key contact, the Contractor shall immediately notify EOHHS whenever the position becomes vacant and notify EOHHS when the position is filled and by whom; and
5. The Contractor shall submit to EOHHS a listing of its board of directors as of the Contract Effective Date and an updated listing of its board of directors whenever any changes are made.

2.3 Enrollment Activities

A. Enrollment

1. EOHHS will begin self-selection (opt-in) enrollment prior to the initiation of Passive Enrollment. During this period, Medicare-Medicaid Beneficiaries eligible for the Demonstration may choose to enroll into a particular One Care plan. The first Effective Enrollment Date for this initial opt-in period is scheduled for no earlier than October 1, 2013. Eligible Medicare-Medicaid Beneficiaries who do not select a One Care plan or who do not opt out of the Demonstration will be assigned to a One Care plan during Passive Enrollment.
2. EOHHS may conduct Passive Enrollment during the term of the Contract to assign eligible Medicare-Medicaid Beneficiaries who do not select a One Care plan and who do not opt out of the Demonstration. Individuals who opt out of the Demonstration will not be included in Passive Enrollment for the remainder of the Demonstration. Passive Enrollment to the Contractor will begin no sooner than January 1, 2014, and EOHHS will provide notice of Passive Enrollments at least 60 days prior to the effective dates to Eligible Beneficiaries, and will accept opt-out requests prior to the effective date of enrollment. EOHHS will apply intelligent methodologies, to the extent approved by CMS, to assign Eligible Beneficiaries to a One Care plan. Such methodologies may include, but not be limited to, past provider relationships. CMS and EOHHS may stop Passive Enrollment to Contractor if the Contractor does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and EOHHS.
3. Enrollments and disenrollments will be processed through the EOHHS customer service vendor, consistent with the Effective Enrollment Date requirements outlined in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. EOHHS or its vendor will then submit Passive Enrollment transactions at least 60 days in advance of the effective date, to the CMS Medicare Advantage Prescription Drug (MARX) enrollment system directly or via a third-party CMS designates to receive such transactions, and MassHealth or its vendor will receive notification on the next Daily Transaction Reply Report. The Contractor will then receive enrollment transactions through the EOHHS customer service vendor. The Contractor will also use the third-party CMS designates to submit

additional enrollment-related information to MARx, and receive files from CMS.

4. Enrollments received by the last calendar day of the month will be effective on the first calendar day of the following month. The Contractor is responsible for providing and paying for Covered Services as of the Effective Enrollment Date of each Enrollee, even if the Contractor is not notified of an Enrollee's enrollment into Contractor's plan until after such Enrollee's Effective Enrollment Date.
5. The Contractor must have a mechanism for receiving timely information about all enrollments in the Contractor's plan, including the Effective Enrollment Date, from CMS and MassHealth systems.
6. The Contractor shall accept enrollments of all Medicare-Medicaid Beneficiaries, as described in Section 3.2 of the Contract, referred by EOHHS in the order in which they are referred without restriction, except that the Contractor shall notify EOHHS of any third party liability in accordance with Section 5.1.M. The Contractor shall accept for enrollment all Medicare-Medicaid Beneficiaries identified by EOHHS at any time without regard to income status, physical or mental condition, age, gender, gender identity, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for Covered Services.
7. Upon instruction by EOHHS, the EOHHS customer service vendor may not provide new enrollments within six months (or less) of the end date of the Demonstration, unless the Demonstration is renewed or extended.
8. EOHHS and CMS will monitor enrollments and Passive Enrollment auto-assignments to all One Care plans, and may make adjustments to the volume and spacing of Passive Enrollment periods based on the capacity of the Contractor, and of One Care plans in aggregate, to accept projected Passive Enrollments. Adjustments to the volume of Passive Enrollment based on the capacity of the Contractor will be subject to any capacity determinations including but not limited to those documented in the CMS and EOHHS final readiness review report and ongoing monitoring by CMS and EOHHS.
9. CMS and EOHHS, upon agreement of both parties, may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

10. The Contractor may, via the Contract Management Team, request a capacity limit pursuant to 42 C.F.R. § 422.60. For the purposes of this Demonstration, CMS and EOHHS will consider a number of factors, including financial stability and network adequacy, in the determination of a capacity limit.

B. Disenrollment

The Contractor shall:

1. Have a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and MassHealth systems. All enrollments and disenrollment-related transactions will be performed by the EOHHS customer service vendor. Enrollees can elect to disenroll from the One Care plan or the Demonstration at any time and enroll in another One Care plan, a Medicare Advantage plan, PACE, or Senior Care Options (if they meet applicable eligibility requirements); or may elect to receive services through Medicare fee-for-service and a prescription drug Plan and to receive Medicaid services in accordance with the Commonwealth's state plan and any waiver programs. Disenrollments received by MassHealth or its contractor, or by CMS or its contractor by the last calendar day of the month will be effective on the first calendar day of the following month;
2. Be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment;
3. Notify EOHHS of any individual who is no longer eligible to remain enrolled in the ICO per CMS enrollment guidance, in order for EOHHS to disenroll the individual. This includes where an Enrollee remains out of the Service Area or for whom residence in the plan Service Area cannot be confirmed for more than six consecutive months;

4. Not interfere with the Enrollee's right to disenroll through threat, intimidation, pressure, or otherwise;
5. Not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of treatment plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation, to the Contract Management Team (CMT) to disenroll an Enrollee, for cause, for the following reason:
 - a. The Enrollee's continued enrollment seriously impairs the Contractor's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

C. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to One Care Plans on discretionary involuntary disenrollment. This Contract, the regulation, and other guidance provide procedural and substantive requirements the Contractor must follow prior to being approved to involuntarily disenroll an Enrollee. If all of the procedural requirements are met to the satisfaction of EOHHS and CMS, EOHHS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of the particular facts associated with each request.

1. If EOHHS and CMS determine that the Contractor too frequently requests termination of enrollment for Enrollees, EOHHS and CMS reserve the right to deny such requests and require the Contractor to initiate steps to improve the Contractor's ability to serve such Enrollees.
2. To support EOHHS' and CMS' evaluation of a Contractor's requests for involuntary disenrollment, the Contractor shall, in all cases, document

what steps the Contractor has taken to locate and engage the Enrollee, and the impact of or response to each attempt.

3. Bases for Discretionary Involuntary Disenrollment:

a. Disruptive conduct: When the Enrollee engages in conduct or behavior that substantially impairs the Contractor's ability to provide for or arrange Covered Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

1. Procedural requirements:

- a.** The Contractor's request must be in writing and include all of the supporting documentation outlined in the evidentiary requirements.
- b.** The Contractor must follow the process for Involuntary Disenrollment as outlined in Sections 40.3 and 40.4 and in the Massachusetts-specific appendix of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.
- c.** The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;
- d.** The submission must include statements from providers describing their experiences with the Enrollee (or written refusal, to provide such statements); and
- e.** Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.
- f.** If the Contractor is requesting the ability to decline future enrollments for this individual, the Contractor must include this request explicitly in the submission.
- g.** Prior to approval, the complete request must be reviewed by EOHHS and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

- 2. Evidentiary standards; At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both EOHHS and CMS staff with appropriate clinical or medical expertise:**
 - a. The Enrollee is presently engaging in a pattern of disruptive conduct that is substantially impairing the Contractor's ability to arrange for or provide Covered Services to the Enrollee and/or other Enrollees.
 - b. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:
 - i. A documented effort to address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. EOHHS and CMS will determine whether the reasonable accommodations offered are sufficient.
 - ii. A documented provision of information to the Enrollee of his or her right to use the Contractor grievance procedures.
 - c. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.
 - d. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of Covered Services.
 - e. The Contractor may also provide evidence of other extenuating circumstances;
- 3. Limitations:** The Contractor shall not seek to terminate Enrollment because of any of the following:
 - a. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless the Enrollee's continued Enrollment in the Plan

4. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the Contractor's decision and information on the Enrollee's access to grievance procedures and a fair hearing.
6. Transfer Enrollee record information promptly to the new provider upon written request signed by the disenrolled Enrollee;
7. If the Enrollee transfers to a plan offered by another One Care contractor, with the Enrollee's written consent, in accordance with applicable laws and regulations, promptly transfer current Minimum Data Set-Home Care (MDS-HC) assessment information to the new One Care contractor; and
8. Notify EOHHS if the Contractor becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

D. Initial Enrollee Contact and Orientation

The Contractor must:

1. Provide an orientation, to Enrollees, within 30 calendar days of the initial date of enrollment. The orientation shall include:
 - a. Materials and a welcome call;
 - b. For Enrollees with current Primary Care Providers (PCPs) out of network, making reasonable efforts to contract with their Primary Care Providers (See **Section 2.7.A.8**);

- c. For Enrollees without a current Primary Care Provider identified at the time of enrollment, assisting the Enrollee to identify and if desired retain their current Primary Care Provider or choose a Primary Care Provider. If an Enrollee does not identify a current PCP or select a PCP within 90 days of enrollment, and the Contractor has made reasonable, unsuccessful attempts to engage the Enrollee in identifying or selecting a PCP, the Contractor shall assign a PCP to the Enrollee and notify the Enrollee of the assignment;

 - d. Working with the Enrollee to schedule a Comprehensive Assessment (see **Section 2.6.A**); and

 - e. Any pre-enrollment materials specified in **Section 2.3** that, due to a late month enrollment request, were not provided prior to the time of enrollment.
- 2. For Enrollees with a current Primary Care Provider that is not in network and refuses to become a Network Provider or enter into a single-case out-of-network agreement where applicable (see **Section 2.7.A.8**), assist the Enrollee to choose a Primary Care Provider. The Enrollee must choose a new Primary Care Provider by the end of the 90-day continuity of care period or after the Individualized Care Plan is developed. If the Enrollee has not chosen an in-network Primary Care Provider by that time, the Contractor shall choose one for the Enrollee.

 - 3. Make available to family members, significant informal caregivers, and designated representatives, as appropriate, any enrollment and orientation materials upon request and with consent of the enrollee;

 - 4. For Enrollees for whom written materials are not appropriate, provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations;

5. Notify its Enrollees:
 - a. That translations of written information are available in Prevalent Languages;
 - b. That oral interpretation services are available for any language spoken by Enrollees and Eligible Beneficiaries free of charge;
 - c. How Enrollees can access oral interpretation services;
 - d. How Enrollees can access nonwritten materials described in Section 4 above; and
 - e. How Enrollees can make a standing request to receive all future notifications and communication in a specified Alternative Format.
6. Ensure that all orientation materials are provided in a manner and format that may be easily understood, including providing written materials in Prevalent Languages and oral interpretation services when requested.

2.4 Covered Services

- A. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See **Appendix A** and **Appendix B**). Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services will be managed and coordinated by the Contractor through the Interdisciplinary Care Team (ICT) (see **Section 2.5.B**).

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

2.5 Care Delivery Model

A. Primary Care

The PCP must:

1. Provide primary medical services, including acute and preventive care;
2. Refer the Enrollee, in coordination with the ICT and in accordance with the Contractor's policies, to Covered Service providers, as medically appropriate; and
3. Lead the ICT, together with the Care Coordinator, and if indicated, with the behavioral health clinician.

B. Interdisciplinary Care Team (ICT)

1. The Contractor must arrange for each Enrollee, in a manner that respects the needs and preferences of the Enrollee, the formation and operation of an ICT. The Contractor will ensure that each Enrollee's care is integrated and coordinated within the framework of an ICT and that each ICT member has a defined role appropriate to his or her licensure and relationship with the Enrollee. The Enrollee will be encouraged to identify individuals he or she would like to participate on the ICT.

2. The ICT will consist of at least the following staff:
 - a. PCP;
 - b. Behavioral health clinician, if indicated;
 - c. Care Coordinator or Clinical Care Manager, as indicated; and
 - d. IL-LTSS Coordinator, if indicated, as specified in Section 2.5.C.4.g.
3. As appropriate and at the discretion of the Enrollee, the ICT also may include any or all of the following participants:
 - a. Registered nurse;
 - b. Specialist clinician;
 - c. Other professional and support disciplines including social workers, Community Health Workers, and qualified peers;
 - d. Family members;
 - e. Other informal caregivers;
 - f. Advocates; and
 - g. State agency or other case managers.
4. The Contractor must:
 - a. Recruit, select, train, manage, and employ or contract with appropriate and qualified personnel, including PCPs, behavioral health clinicians, Care Coordinators and IL-LTSS Coordinators, and will maintain staffing levels necessary to perform its responsibilities under the Contract;
 - b. Document that all members of the ICT have participated in required training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles;
 - c. Ensure that the ICT is accessible to the Enrollee, including by providing alternatives to office visits, including, as appropriate, home visits, email and telephone contact; and

- d. Have a mechanism to identify Enrollees that meet the state criteria for Enrollees with Special Health Care Needs, and have policies and procedures for granting these identified individuals direct access to a specialist.
5. The ICT must:
- a. With the Enrollee and/or the Enrollee's designated representative, if any, and with all appropriate ICT members, including the Enrollee, develop an ICP, that includes treatment goals (medical, functional, and social) and measures progress and success in meeting those goals (see Section 2.6.C);
 - b. On an ongoing basis, consult with and advise acute, specialty, LTSS, and Behavioral Health Providers about care plans and clinically appropriate interventions;
 - c. With the assistance of the Care Coordinator and/or IL-ILTSS Coordinator as appropriate, promote independent functioning of the Enrollee and provide services in the most appropriate, least restrictive environment;
 - d. Document and comply with advance directives about the Enrollee's wishes for future treatment and health care decisions;
 - e. Assist in the designation of a health care proxy, if the Enrollee wants one;
 - f. Maintain the Centralized Enrollee Record, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Enrollee (see Section 2.6.F); and
 - g. Communicate with the Enrollee, and, in accordance with the Enrollee's preferences, the Enrollee's family members and significant caregivers, if any, about the Enrollee's medical, social, and psychological needs.

C. Care Coordination

1. The Contractor shall offer care coordination to all Enrollees:

- a. Through a Care Coordinator or Clinical Care Manager (CCM) for medical and Behavioral Health Services; and
- b. Through an Independent Living and Long-Term Services and Supports (IL-LTSS) Coordinator, contracted from a community-based organization, for LTSS.

2. Care Coordinator

The Contractor must establish its own written qualifications for a Care Coordinator. The Contractor is responsible for the appropriate training for the Care Coordinator and verifying that the training or any certifications remain current. The Contractor must have policies in place to address non-compliance with training by the Care Coordinators. The Care Coordinator must:

- a. Act as the single point of contact for an Enrollee to the Contractor and the ICT;
- b. Be a provider-based clinician or other trained professional; or
- c. Be an individual employed or contracted by the Contractor or the Enrollee's Primary Care Provider who is trained in providing care coordination to persons with disabilities;
- d. As a member of the ICT, execute the following responsibilities:
 - (1) Participating in Comprehensive Assessments for care planning;
 - (2) Ensuring that ICT meetings and conference calls are held periodically;
 - (3) Monitoring the provision of services, including outcomes, assessing appropriate changes or additions to services, and making necessary referrals, as needed, for the Enrollee; and
 - (4) Ensuring that appropriate mechanisms are in place to receive Enrollee input, Complaints, and Grievances, and secure communication among relevant parties.

3. Clinical Care Manager

- a. For Enrollees with Complex Care Needs, as determined by the Contractor or a Provider under agreement with the Contractor to assume Clinical Care Management responsibilities, the Care Coordinator will be a Clinical Care Manager. In addition to executing the care coordination responsibilities in **Section 2.5.C.2** the Clinical Care Manager will provide or as appropriate coordinate Clinical Care Management for medical and Behavioral Health Services.
 - b. The Clinical Care Manager must be a licensed registered nurse or other individual licensed and/or certified to provide Clinical Care Management, employed by the Enrollee's Contractor or Primary Care Provider, or patient-centered medical home or health home provider.
 - c. The Clinical Care Manager will provide Clinical Care Management, or, a set of activities that comprise intensive monitoring, follow-up, and Care Coordination and clinical management of Enrollees with Complex Care Needs, including but not limited to:
 - (1) Engagement of the Enrollee into Clinical Care Management;
 - (2) Assessment of the clinical risks and needs of each Enrollee;
 - (3) Identification of the Enrollee's strengths, preferences, and family and community supports that can assist in addressing the clinical risks;
 - (4) Medication review and reconciliation;
 - (5) Medication adjustment by protocol;
 - (6) Enhanced self-management training and support for complex clinical conditions, including coaching for family members if appropriate;
 - (7) Follow-up within 24 hours of an Enrollee's admission to an acute hospital, and coordination with the Enrollee and hospital staff to facilitate hospital discharges; and
 - (8) Frequent Enrollee contact, as appropriate.
4. Independent Living and Long-Term Services and Supports (IL-LTSS) Coordinator
- a. The Contractor will contract with multiple Community-Based Organizations (CBOs) for the IL-LTSS Coordinator role, including at

least one Independent Living Center (ILC), where geographically feasible in its Service Area.

- b. IL-LTSS Coordinators may have specific knowledge or skill sets to serve certain Enrollees, such as individuals who are Deaf or hard of hearing, or individuals with behavioral health needs. Additional CBOs may include, but are not limited to Recovery Learning Communities, Aging Service Access Points (ASAPs), and other CBOs serving people with disabilities.
- c. Enrollees over the age of 60 must be offered the option of receiving IL-LTSS Coordinator services through an ASAP.
- d. The Contractor shall contract with an adequate number of CBOs to allow Enrollees a choice of at least two IL-LTSS Coordinators, except that with EOHHS prior approval, Contractor may offer Enrollee only one IL-LTSS Coordinator.
- e. The Contractor shall not have a direct or indirect financial ownership interest in an entity that serves as a CBO that is contracted to provide IL-LTSS Coordinators. Providers of facility- or community-based LTSS on a compensated basis by an ICO may not function as IL-LTSS Coordinators, except if the Contractor obtains a waiver of this requirement from EOHHS. For the purpose of this provision, an organization compensated by the Contractor to provide only evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services is not considered a provider of LTSS.
- f. The IL-LTSS Coordinator is responsible for the following activities:
 - (1) Representing the LTSS needs of the Enrollee, advocating for the Enrollee and providing education on LTSS to the ICT and the Enrollee;
 - (2) As a member of the ICT, participating in Comprehensive Assessments of the health and Functional Status of Enrollees with LTSS needs, and, at the Enrollee's direction, assisting in the development of the community-based services component of an ICP as necessary to improve or maintain Enrollee health and Functional Status;
 - (3) Arranging and, with the agreement of the ICT, coordinating the authorization and the provision of appropriate community LTSS and resources;

- (4) Assisting Enrollees in accessing Personal Care Attendant Services;
 - (5) Monitoring the appropriate provision and functional outcomes of community LTSS, according to the ICP, as deemed appropriate by the ICT;
 - (6) Determining community-based alternatives to long-term care; and
 - (7) Assessing appropriateness for facility-based LTSS, if indicated; including assessing any accommodation or access needs, including accessibility requirements and equipment needs.
- g. The IL-LTSS Coordinator will participate as a full member of the ICT for all Enrollees with LTSS needs, at the discretion of the Enrollee. The Contractor must provide information about the IL-LTSS Coordinator to all Enrollees and offer an IL-LTSS Coordinator to all Enrollees within 90 days of each Enrollee's Effective Enrollment Date. The Contractor must make an IL-LTSS Coordinator available:
- (1) During Comprehensive Assessments for all Enrollees in C3, including C3A and C3B, and in F1 Rating Categories, and for all Enrollees in any Rating Category who request it;
 - (2) At any other time at an Enrollee's request;
 - (3) When the need for community-based LTSS is identified by the Enrollee or ICT;
 - (4) If the Enrollee is receiving targeted case management, is receiving rehabilitation services provided by the Department of Mental Health, or has an affiliation with any state agency; or
 - (5) In the event of a contemplated admission to a nursing facility, psychiatric hospital, or other institution.
- h. The IL-LTSS Coordinator will assist in identifying a more appropriate IL-LTSS Coordinator if, after a Comprehensive Assessment, it is determined that the Enrollee has specific needs outside of the IL-LTSS Coordinator's expertise.
- i. The Contractor must establish written qualifications for the IL-LTSS Coordinator that include, at a minimum:

- (1) Bachelor's degree in social work or human services, or at least two years working in a human service field with the population eligible for the Demonstration;
- (2) Completion of person-centered planning and person-centered direction training;
- (3) Experience working with people with disabilities or elders in need of LTSS;
- (4) Knowledge of the home and community-based service system and how to access and arrange for services;
- (5) Experience conducting LTSS needs assessments and monitoring LTSS delivery;
- (6) Cultural competency and the ability to provide informed advocacy;
- (7) Ability to write an ICP and communicate effectively, both verbally and in writing across complicated service and support systems; and
- (8) Meet all requirements of their CBO employer.

D. Long-Term Services and Supports

1. Long-Term Services and Supports Delivery System

In delivering the Covered Services referenced in **Appendix A** and defined in **Appendix B** that relate to Long-Term Services and Supports, the Contractor must demonstrate the capacity to provide coordination of care and expert care management through the ICT. The Contractor must ensure that:

- a. The IL-LTSS Coordinator executes the responsibilities described in **Section 2.5.C.4.f**;
- b. The Care Coordinator and IL-LTSS Coordinator, as part of the ICT, participate in determinations of appropriateness for institutional and community long term care services; and
- c. The measurement of the Functional Status of Enrollees is performed at Comprehensive Assessments. Reports will be produced in accordance with **Appendix N**.

2. Continuum of Long-Term Care:

The Contractor must provide:

- a. Community alternatives to institutional care;
- b. Other transitional, respite, and support services in the home to maintain Enrollees safely in the community, based on assessment of Functional Status by the Contractor;
- c. Nursing facility services for Enrollees who meet applicable screening requirements and desire such services (see Appendix N for reporting requirements);
- d. Assistance with activities of daily living with alternate staffing available at all times; and
- e. Other institutional and community-based services as determined by the ICT.

3. Pre-Admission Screening and Resident Review (PASRR) Evaluation

The Contractor must comply with federal regulations requiring referral of nursing facility-eligible beneficiaries, as appropriate, for PASRR evaluation for individuals seeking admission to a nursing facility that may or do have the diagnosis of Intellectual Disability, Developmental Disability, or Mental Illness pursuant to the Omnibus Reconciliation Act (OBRA) of 1987.

E. Behavioral Health

1. General

- a. The Contractor shall ensure that all Behavioral Health Providers who serve on an Enrollee's ICT:
 - (1) Participate in the initial development and ongoing implementation of an ICP for the Enrollee; and
 - (2) On an ongoing basis, consult with and advise the ICT or other acute, specialty, LTSS, and Behavioral Health Providers about care plans and clinically appropriate interventions, including after transitions of care where the Enrollee will benefit from or need re-assessment and may require ICP modifications.

- b. With the assistance of the Care Coordinator, IL-ILTSS Coordinator, or Clinical Care Manager as appropriate, promote independent functioning of the Enrollee and provide services to the Enrollee in the most appropriate, least restrictive environment; and
- c. Comply with the provisions of **Section 2.5.H.2** with regard to coordination with the Department of Mental Health (DMH) for Enrollees with a DMH affiliation.

2. Systematic Early Identification and Intervention for Behavioral Health Services

- a. Behavioral health concerns must be systematically identified and addressed by the Enrollee's PCP and/or ICT at the Comprehensive Assessments through the use of appropriate behavioral health screening tools. When appropriate, the Contractor must ensure that referrals for specialty Behavioral Health Services are made promptly, monitored, and with Enrollee consent and per Enrollee preferences documented in the Comprehensive Assessment (see **Section 2.6.A.3.c.2**), documented in the Centralized Enrollee Record (see **Section 2.6.F**).

3. Services for Enrollees with Serious and Persistent Mental Illness

- a. The Contractor must ensure that Enrollees with serious and persistent mental illness have access to ongoing medication review and monitoring, outpatient treatment, rehabilitation, recovery and support programs, and other milieu alternatives to conventional therapy. The ICT must coordinate services with additional support services as appropriate. For such Enrollees, a qualified behavioral health clinician (see **Section 2.8.C.3**) must be part of the ICT. As necessary, care coordination with the DMH and its contracted programs that serve the Enrollee must be provided.
- b. The Contractor and providers must comply with the Mental Health Parity and Addiction Equity Act of 2008, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate

treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

4. Continuum of Behavioral Health Care

The Contractor must offer a continuum of behavioral health care as specified in the Covered Services in **Appendix A** and defined in **Appendix B** that is coordinated with PCPs or ICTs, as appropriate, and includes but is not limited to:

- a. A range of services from acute inpatient treatment to intermittent professional and supportive care for delivering Behavioral Health Services to Enrollees residing in the community or in long-term care settings; and
- b. Diversionary services that offer safe community alternatives to inpatient hospital services.

5. Behavioral Health Responsibilities

The Contractor must manage timely access to and the provision of all Behavioral Health Services by establishing and contracting with a Behavioral Health Provider Network. When services for Emergency Conditions are needed, the Enrollee may seek care from any qualified Behavioral Health Provider, including Emergency Services Program (ESP) providers. The care-management protocol for Enrollees must encourage appropriate access to behavioral health care in all settings. For Enrollees who require Behavioral Health Services, the Behavioral Health Provider must:

- a. With the Enrollee and/or the Enrollee's authorized representative, if any, develop the behavioral health portion of the ICP for each Enrollee in accordance with accepted clinical guidelines;
- b. With the input of the PCP and/or ICT, as appropriate, determine clinically appropriate interventions on an on-going basis, with the goal

of promoting the independent functioning of the Enrollee and the stabilization, continuing improvement, or recovery from behavioral health conditions;

c. Ensure that access to Behavioral Health Services for Enrollees is consistent with the degree of urgency, as follows:

- (1) Emergency Services shall be provided immediately (respond to call with a live voice; or face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to Enrollees who present at any qualified Provider, whether a Network Provider or a non-Network Provider;
- (2) ESP Services shall be provided immediately to Enrollees on a 24-hour basis, seven days a week, with unrestricted access;
- (3) Urgent Care Services shall be provided within 48 hours; and
- (4) All other care shall be provided within 14 calendar days.

d. With Enrollee consent and per Enrollee preferences documented in the Comprehensive Assessment (see **Section 2.6.A.3.c.2**), make appropriate and timely entries into the Centralized Enrollee Record about the behavioral health assessment, diagnosis determined, medications prescribed, if any, and ICP developed. As stated in **Section 2.6.F.4.d**, psychotherapeutic session notes must not be recorded in the Centralized Enrollee Record; and

e. Obtain authorization from the PCP and/or ICT, as appropriate, for any nonemergency services, except when authorization is specifically not required under this Contract.

6. Coordination of Medication

The Contractor is responsible for ensuring that prescriptions for any psychotropic medications are evaluated for interactions with the medications already prescribed for the Enrollees.

7. Behavioral Health Needs Management

The Contractor must maintain a structured process for identifying and addressing complex behavioral health needs at all levels of care and in all residential settings. Qualified Behavioral Health Providers must proactively coordinate and follow Enrollee progress through the continuum of care.

F. Health Promotion and Wellness Activities

The Contractor must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other significant informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behaviors in the Medicare-Medicaid population. Interpreter services must be available for Enrollees who are not proficient in English. Examples of health promotion and prevention seminar topics include, but are not limited to the following:

1. Chronic condition self-management;
2. Smoking cessation;
3. Nutrition; and
4. Prevention and treatment of alcohol and substance abuse.

G. Other Professional and Support Disciplines

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

- a. Wellness coaching to engage the Enrollee in prevention activities such as smoking cessation, exercise, diet, and obtaining health screenings;
 - b. Evidence-based practices and techniques for chronic disease self-management;
 - c. Qualified peer support for Enrollees with mental health and substance use disorders to assist such Enrollees in their recovery, and for Enrollees with physical disabilities to assist such Enrollees in the pursuit of independent living; and
 - d. Community supports for newly housed Enrollees who have experienced chronic homelessness.
2. Community Health Workers must be available and appropriate for the populations served, such as for Enrollees who are Deaf or hard of hearing.

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

1. General

a. Agencies

The Contractor must implement a systematic process for coordinating care and creating linkages between Enrollees and organizations that provide services not covered under the Demonstration, including but not limited to:

- (1) State agencies (e.g. the Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and DPH's Bureau of Substance Abuse Services, Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH),

Massachusetts Rehabilitation Commission, and the Executive Office of Elder Affairs (EOEA));

- (2) Social service agencies;
- (3) Community-based mental health and substance use disorder programs;
- (4) Consumer, civic, and religious organizations; and
- (5) Federal agencies (e.g. the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).

b. Requirements

The systematic process and associated linkages must provide for:

- (1) Sharing information and generating, receiving, and tracking referrals;
- (2) Obtaining and recording consent from Enrollees to share individual Enrollee medical information where necessary; and
- (3) Ongoing coordination efforts (for example, regularly scheduled meetings, newsletters, and joint community-based projects).

2. Department of Mental Health (DMH)

The Contractor shall ensure that services are provided to Enrollees with DMH affiliation as follows:

- a. Ensure that Covered Services are delivered to all Enrollees;
- b. Ensure that the ICT communicates with the DMH caseworker(s) assigned to Enrollees and informs them of the services provided through the Contractor's plan;
- c. Ensure that for all DMH clients, a release of information is requested to be used to inform the agency of the Enrollee's current status;
- d. Ensure that for all DMH clients, the ICP specifies all Behavioral Health Services required during any acute Behavioral Health Inpatient Services stay, identifies discharge plans and, when appropriate, indicates the need for DMH Continuing Care Services as part of the ICP; and
- e. Designate a DMH liaison to work with MassHealth and DMH. Such liaison shall:
 - (1) Have at least two years of care management experience, at least one of which must be working with individuals in need of significant Behavioral Health Services;
 - (2) Actively participate in the planning and management of services for individuals who are clients of DMH. This shall include, but not be limited to:
 - (A) Establishing and maintaining contact with designated DMH case managers, as identified by DMH, and assisting MassHealth and DMH in resolving any problems or issues that may arise with a DMH-affiliated Enrollee;
 - (B) Upon request of DMH, participating in regional informational and educational meetings with DMH staff and, as directed by DMH, family members and peer support workers;
 - (C) As requested by DMH, providing advice and assistance to regional directors or case managers on individual cases regarding Covered Services and coordinating non-covered services;

- (D) If requested by DMH, working with providers of 24-hour inpatient or diversionary services to coordinate discharge planning;
- (E) As requested by MassHealth, actively participating in any joint meetings or workgroups with MassHealth or other EOHHS agencies;
- (F) Performing any functions to assist the Contractor in complying with the requirements of **Section 2.5.H.1**; and
- (G) Assisting DMH caseworkers with obtaining appointments in compliance with **Section 2.9.B**;

3. Department of Developmental Services (DDS)

The Contractor shall ensure that services are provided to Enrollees with DMH affiliation as follows: The Contractor shall:

- a. Ensure that Covered Services are delivered to all Enrollees;
- b. Ensure that the ICT communicates with the DDS caseworker(s) assigned to Enrollees and inform them of the services provided through the Contractor's Plan;
- c. Designate a DDS liaison to work with MassHealth and DDS. Such liaison shall:
 - (1) Have at least two years of care management experience, at least one of which must be working with individuals in need of services related to developmental or intellectual disability;
 - (2) Actively participate in the planning and management of services for individuals who are clients of DDS. This shall include, but not be limited to:
 - (A) Establishing and maintaining contact with designated DDS case managers, as identified by DDS, and assisting MassHealth and DDS in resolving any problems or issues that may arise with a DDS-affiliated Enrollee;
 - (B) Upon request of DDS, participating in regional informational and educational meetings with DDS staff;
 - (C) As requested by DDS, providing advice and assistance to regional directors or case managers on individual cases

regarding Covered Services and coordinating non-covered services;

(D) If requested by DDS, working with providers of 24-hour inpatient or diversionary services to coordinate discharge planning;

(E) As requested by MassHealth, actively participating in any joint meetings or workgroups with MassHealth or other EOHHS agencies;

(F) Performing any functions to assist the Contractor in complying with the requirements of **Section 2.5.H.1**; and

(G) Assisting DDS caseworkers with obtaining appointments in compliance with **Section 2.9.B**.

4. The Contractor shall designate a liaison to work with designated EOHHS staff and the EOHHS Office of Disability Policy and Programs (ODPP). Such liaison shall:

a. Have at least two years of care management experience, at least one of which must be working with adults who:

(1) Have developmental disabilities;

(2) Have severe physical disabilities;

(3) Are Deaf or hard of hearing; or

(4) Are blind or visually impaired;

b. Establish and maintain contact with designated ODPP staff and be available to assist EOHHS and ODPP in the resolution of any problems or issues that may arise with an Enrollee affiliated with an ODPP agency, including Massachusetts Rehabilitation Commission (MRC), Massachusetts Commission for the Blind (MCB), and Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH);

c. As requested by ODPP, participate in regional informational and educational meetings with EOHHS staff or staff of any of the ODPP agencies, and, as directed by EOHHS, individuals, caregivers, or other family member(s);

- d. As requested by ODPP, provide advice and assistance to DDS, MRC, MCB, MCDHH, and other State agencies as may be needed, on individual cases regarding Covered Services and coordinating non-covered services provided by State agencies other than MassHealth; and
- e. As requested by EOHHS, actively participate in any joint meetings or workgroups with EOHHS agencies.

I. Integration and Coordination of Services

- 1. The Contractor must promote and support advances in PCPs' and other providers' capabilities to perform as patient-centered medical homes and/or health homes that provide integrated primary care and behavioral health care. This may take the form of Behavioral Health Services being integrated into a primary care setting or vice versa. The Contractor must support capacity development in at least the Foundational Elements of Primary Care and Behavioral Health Integration described in **Appendix L**. With regard to the overall integration and coordination of medical, behavioral health and LTSS, beyond supporting ICTs, the Contractor may also use qualified peers and non-medical staff (e.g., Community Health Workers) to support and connect Enrollees with community-based resources.
- 2. The Contractor shall have written protocols for:
 - a. Generating or receiving referrals and for recording and tracking the results of referrals;
 - b. Providing or arranging for second opinions, whether in- or out-of-network at no cost to the Enrollee;
 - c. Sharing clinical data and ICT information, including management of medications;
 - d. Determining conditions and circumstances under which specialty services will be provided;
 - e. Tracking and coordination of Enrollee transfers from one setting to another (for example, hospital to home and nursing home to adult day health) and ensuring the provision of necessary new or Continuing Services and supports to minimize unnecessary complications related to care setting transitions;

- f. Obtaining and sharing individual medical and care planning information among the Enrollee's caregivers, and with CMS and EOHHS for quality management and evaluation purposes; and
- g. Integrating into the ICT care planning process and the ICP, as appropriate, hospice services that may be received by an Enrollee from a hospice provider.

2.6 Comprehensive Assessments and Individualized Care Plan

A. Comprehensive Assessment

1. The Contractor must complete Comprehensive Assessments for each new Enrollee on an ongoing basis, including:
 - a. Within 90 days of each Enrollee's Effective Enrollment Date into the Contractor's plan, and at least annually thereafter; or
 - b. Whenever an Enrollee experiences a major change that is:
 - (1) Not temporary or episodic;
 - (2) Impacts on more than one area of health status; and
 - (3) Requires interdisciplinary review or revision of the ICP.
2. The Contractor must record Comprehensive Assessment results in the Centralized Enrollee Record.

3. The Comprehensive Assessment must include completion of an assessment tool, developed by the Contractor and informed by at least one in-person meeting covering expanded domains as may be relevant for each Enrollee to creation of his or her ICP. This activity may be conducted at the same time as the MDS-HC assessment or at a different time, and must be completed within the continuity of care period.
 - a. As appropriate to the Enrollee's needs and preferences, the Contractor-developed assessment tool will include the following domains and special considerations, which may be updated by EOHHS during the Contract period:
 - (1) Immediate needs and current services, including preventive health, preferred providers, what is working well for the Enrollee and what can be improved;
 - (2) Health conditions, including conditions of known prevalence among subpopulations, such as seizures, aspiration, constipation, dehydration, and pica for individuals with intellectual disabilities;
 - (3) Current medications, including how long the Enrollee has been taking each medication, and any need for immunizations or vaccines;
 - (4) The ability of the individual to communicate their concerns or symptoms, including if the individual can verbalize issues and/or whether physical symptoms are manifested through behavior;
 - (5) Functional Status, including ADL and IADL limitations, and what the Enrollee identifies as his/her strengths, weaknesses, interests, and choices about daily routine;

- (6) Current mental health and substance use, and history of mental health and substance use treatment, including consideration of:
 - (A) Type, duration and frequency of services, including medications;
 - (B) Specialized supports that may be needed, particularly for individuals who utilize the emergency room for a psychiatric or behavioral issue;
 - (C) Earlier onset of dementia for individuals with intellectual disabilities;
- (7) Personal goals, including health goals and activities enjoyed by the Enrollee and barriers to participating;
- (8) Accessibility requirements including:
 - (A) specific communication needs, such as language interpreters/translators, written materials and support to understand treatment options;
 - (B) needs for transfer equipment;
 - (C) needs for personal assistance;
 - (D) appointment scheduling needs;

(E) communication preference;

(F) health literacy;

(G) additional adaptations for appointment and screenings, such as adaptive equipment; and

(H) Assistance needed to keep track of appointments and get to them;

(9) Equipment needs including adaptive technology;

(10) Transportation access, including equipment needed during transportation, and both medical and non-medical transportation needs;

(11) Housing/home environment, including:

(A) Considerations specific to homeless Enrollees;

(B) Risk of homelessness;

(C) Home accessibility requirements;

(D) Housing preferences, including who the Enrollee lives with;

(E) Methods for heating and cooling Enrollee's home;

(F) Home safety; and

(G) Any services provided in a residential setting;

(12) Employment status and interest, including school and volunteer work, employment services currently provided to the Enrollee, employment goals and barriers to achieving goals;

(13) Involvement or affiliation with other Care Coordinators, care teams, or other State agencies, including current and past involvement, use of self-directed services through state agencies, and agency contacts;

(14) Informal supports/caregiver supports, including availability of back-up for informal supports, caregiver needs, and Enrollee's caregiver responsibilities (e.g. children, spouse, parents);

(15) Risk factors for abuse and neglect in the Enrollee's personal life or finances;

(16) Use of leisure time and community involvement, including preferences, goals and barriers;

(17) Social supports, including:

(A) Cultural and ethnic orientation or personal beliefs towards the Enrollee's presenting problems that may influence the Enrollee's health care; and

(B) Involvement with peer support groups;

(18) Food security and nutrition, including:

(A) Food availability;

(B) Access and barriers to healthy food;

(C) Oral hygiene;

(D) Need for food stamps or meals programs;

(E) Nutritional supplements;

(19) Wellness and exercise, including types of exercise, self-rated wellness, and prevention strategies;

(20) Advance directive/guardianship, including health care proxy and power of attorney; and

(21) Other domains and/or considerations as may be required by EOHHS.

b. For all Enrollees, the Contractor-developed assessment tool will also capture information regarding:

- (1) The Enrollee's understanding of available services;
- (2) The Enrollee's desire to self-manage all or part of his or her care plan regardless of the severity of disability, and the Enrollee's understanding of his or her self-management responsibilities;
- (3) The Enrollee's preferences regarding privacy, services, caregivers, and daily routine; and
- (4) The Enrollee's understanding of his or her rights, in accordance with **Appendix C**.

c. For Enrollees identified by the Contractor, including through the referral, enrollment, or assessment processes as having behavioral health needs, the Contractor-developed assessment tool will also capture information regarding:

- (1) The Enrollee's understanding of, engagement in, and desire to be engaged in recovery-oriented activities; and
- (2) The Enrollee's preferences about the privacy of his or her behavioral health information, including diagnoses and services received.

4. The Enrollee will be at the center of the assessment and care planning process. The Contractor will ensure that the Enrollee receives information about the Comprehensive Assessment and any necessary assistance and accommodations to prepare for and fully participate in the Comprehensive Assessment.
5. The Contractor will complete the Comprehensive Assessment in a location that meets the needs of the Enrollee, including home-based assessments as appropriate. With the Enrollee's consent the Contractor will also gather information from the Enrollee's providers or other sources of support.
6. Using the information gathered from the Comprehensive Assessment, the Contractor will work with the Enrollee to develop an ICP (see **Section 2.6.B** below).

B. MDS-HC Assessment

The Contractor must complete MDS-HC assessments for its Enrollees as described below. The MDS-HC must be completed in-person by a registered nurse. Information collected on the MDS-HC must be sent to MassHealth via the MDS-HC application in the Commonwealth's Virtual Gateway to ensure accurate assignment of Rating Categories. The Contractor must cooperate with and participate in any and all requests made by MassHealth for further information concerning any MDS-HC submission. The MDS-HC must be completed as follows:

1. For Enrollees assigned to the C1 Rating Category, the MDS-HC must be completed to change the Rating Category;
2. For Enrollees assigned to the C2 Rating Categories, including C2A and C2B, the MDS-HC must be completed within 6 months of the Enrollee's Effective Enrollment Date into One Care, and at least annually thereafter;

3. For Enrollees assigned to the C3 Rating Categories, including C3A and C3B, the MDS-HC must be completed within 90 days of the Enrollee's Effective Enrollment Date into One Care and at least annually thereafter; and
4. In order to change any Enrollee's Rating Category to a Rating Category, other than the F1 Rating Category based on the Enrollee's current residence in a long-term care facility for at least 90 days.

C. Individualized Care Plan

1. The Contractor must engage each Enrollee in ongoing development of their ICP.
2. The Contractor must ensure that the ICT integrates and coordinates services, including, but not limited to engaging each Enrollee in the development of an ICP. The ICP must:
 - a. Incorporate the results of the Comprehensive Assessment and specify any changes in providers, services, or medications.
 - b. Be developed by the ICT under the direction of the Enrollee (and/or the Enrollee's representative, if applicable), and in consultation with any specialists caring for the Enrollee, in accordance with 42 C.F.R. 438.208(c)(3) and 42 C.F.R. 422.112(a)(6)(iii) and updated periodically to reflect changing needs identified in Comprehensive Assessments. The Enrollee will be at the center of the care planning process.
 - c. Reflect the Enrollee's preferences and needs. The Contractor will ensure that the Enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process, including the development of the ICP, and that the Enrollee receives clear information about:
 - (1) His/her health status, including functional limitations;
 - (2) How family members and social supports can be involved in the care planning as the Enrollee chooses;

(3) Self-directed care options and assistance available to self-direct care;

(4) Opportunities for educational and vocational activities; and

(5) Available treatment options, supports and/or alternative courses of care.

d. Specify how services and care will be integrated and coordinated among health care providers, and community and social services providers where relevant to the Enrollee's care;

e. Include, but is not limited to:

(1) A summary of the Enrollee's health history;

(2) A prioritized list of concerns, goals and strengths;

(3) The plan for addressing concerns or goals;

(4) The person(s) responsible for specific interventions; and

(5) The due date for each intervention.

3. The Contractor must establish and execute policies and procedures that provide mechanisms by which an Enrollee can sign or otherwise convey approval of his or her ICP when it is developed and at the time of subsequent modifications to it. The Contractor must:

a. Inform an Enrollee of his or her right to approve the ICP;

b. Provide mechanisms for an Enrollee to sign or otherwise convey approval of the ICP that meet his or her accessibility needs; and

c. Inform an Enrollee of his or her right to an Appeal of any denial, termination, suspension, or reduction in services, or any other change in providers, services, or medications, included in the ICP.

D. Continuity of Care

1. For all services other than Part D drugs, the Contractor must develop policies and procedures to ensure continuity of care for all Enrollees for whichever is the longer of:
 - a. A period of up to 90 days, unless the Comprehensive Assessment and the ICP are completed (developed and reviewed with the Enrollee, including any changes in providers, services, or medications) sooner and the Enrollee agrees to the shorter time period; or
 - b. Until the Comprehensive Assessment and ICP are complete (developed and reviewed with the Enrollee, including any changes in providers, services, or medications).
2. Such policies and procedures shall be for the purpose of:
 - a. Ensuring that the Enrollee is established with any new service providers, as indicated by the ICP, so that no gap in ongoing services occurs;
 - b. Allowing Enrollees to maintain their current providers at current Medicare or MassHealth FFS provider rates; and
 - c. Honoring prior authorizations at the time of enrollment that have been issued by MassHealth and Medicare until the ICP is complete.
3. In addition, such policies and procedures shall address:
 - a. Medical record documentation;
 - b. Coordination and consultation with the Enrollee's existing providers;
 - c. Review of all existing prior authorizations and prescriptions; and

- d. For Enrollees affiliated with other State agencies, coordination and consultation with such agencies as described in **Sections 2.5.B.3.g** and **2.6.D.3**.
- e. A process for accepting from MassHealth and utilizing an Enrollee's medical records, claims histories, and prior authorizations. The process shall require the Contractor to, at a minimum:
 - (1) Ensure that there is no interruption of Covered Services for Enrollees;
 - (2) Accept the transfer of all medical records and care management data, as directed by EOHHS; and
 - (3) Accept the transfer of all administrative documentation, as directed by EOHHS, including but not limited to:
 - (A) Provider fraud investigations;
 - (B) Grievances and Appeals;
 - (C) Quality Management plan; and
 - (D) Quality improvement project records;
- f. For pregnant Enrollees:
 - (1) If a pregnant Enrollee enrolls with the Contractor, the Enrollee may choose to remain with her current provider of obstetrical and gynecological services until six weeks after delivery of the child, even if such provider is not in the Contractor's Provider Network;
 - (2) The Contractor is required to cover all Medically Necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six weeks of delivery, even if the provider of such services is not in the Contractor's Provider Network; and
 - (3) If a pregnant Enrollee would like to select a new provider of obstetrical and gynecological services within the Contractor's Provider Network, the Enrollee may do so.

4. The Contractor must offer to contract with all current EOHHS-contracted transportation broker(s) in the Contractor's Service Area(s) to provide Medically Necessary non-Emergency Transportation (as defined in **Appendix B**) services authorized by EOHHS for Enrollees as of each Enrollee's Effective Enrollment Date during the continuity of care period, provided that such transportation broker(s) accept the payment for direct transportation services as established through the payment methodology set forth in such transportation broker(s) contract(s) with EOHHS.
 - a. If EOHHS modifies, adds or terminates contracts with any transportation broker(s) during the term of this Contract, EOHHS shall provide notice to the Contractor of such changes and the Contractor shall ensure that during their continuity of care period Enrollees have access to the same transportation brokers as are available to MassHealth Members on a fee for service basis, including if applicable, offering contracts to new transportation broker(s) according to this **Section 2.6.D.4**.
 - b. The Contractor must provide at least 5 business days' notice to the transportation broker(s) of any changes to the duration of the continuity of care period for an Enrollee that would either reduce or increase it from 90 calendar days.
 - c. EOHHS or its designee shall provide authorization information about Medically Necessary non-Emergency Transportation services for the Contractor's Enrollees to the Contractor.
5. If, as a result of the development of the ICP, or the Comprehensive Assessment, the Contractor proposes modifications to the Enrollee's prior authorized services, the Contractor must provide written notification to the Enrollee about and an opportunity to appeal the proposed modifications, as outlined in **Section 2.12** of this Contract. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable.

6. If an Enrollee is receiving any service that would not otherwise be covered by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as outlined in **Section 2.12** of this Contract.

7. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

E. ICT Discharge Planning Participation

1. The Contractor shall implement policies and procedures that (1) ensure timely and effective treatment and discharge planning; (2) establish the associated documentation standards; (3) involve the Enrollee; and (4) begin on the day of admission. Treatment and discharge planning shall include at least:
 - a. Identification and assignment of a facility based case manager for the Enrollee. This staff member shall be involved in the establishment and implementation of treatment and discharge planning;
 - b. Notification and participation of the Enrollee's ICT in discharge planning, coordination, and re-assessment as needed.
 - c. Identification of the Enrollee's state agency affiliation, release of information, and coordination with any state agency representative assigned to the Enrollee;
 - d. Identification of non-clinical supports and the role they serve in the Enrollee's treatment and after care plans;
 - e. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards;
 - f. Identification of barriers to aftercare, and the strategies developed to address such barriers;

- g. Assurance that inpatient and 24-hour diversionary Behavioral Health Providers provide a discharge plan following any behavioral health admission to ICT members;
- h. Ensure that Enrollees who require medication monitoring will have access to such services within 14 business days of discharge from a behavioral health inpatient setting;
- i. Make best efforts to ensure a smooth transition to the next service or to the community; and
- j. Document all efforts related to these activities, including the Enrollee's active participation in discharge planning.

F. Centralized Enrollee Record and Health Information Exchange

1. Information Network

- a. The Contractor must ensure effective linkages of clinical and management information systems among all Providers in the Provider Network (e.g. acute, specialty, pharmacy, behavioral health and LTSS Providers) including clinical subcontractors by December 31, 2014, leveraging the national standards-based statewide Health Information Exchange where applicable; and
- b. Maintain a communication network that facilitates coordination of care, including use by the ICT of a single electronic medical record to manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site.

2. Centralized Enrollee Record

To coordinate care, the Contractor must maintain a single, centralized, comprehensive record that documents the Enrollee's medical, prescription, functional, and social status. The Contractor must ensure that the PCP and all members of the ICT, as well as any other appropriate

providers, including First Tier, Downstream and Related Entities, make appropriate and timely entries describing the care provided, diagnoses determined, medications prescribed, and treatment plans developed. The Centralized Enrollee Record must contain the following:

- a. Enrollee-identifying information and demographic information (including race, ethnicity, disability type, primary language and homelessness), and family caregiver contact information;
- b. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted; and for prescribed medications, including dosages and any known drug contraindications;
- c. Documentation of physical access and programmatic access needs of the Enrollee, as well as needs for accessible medical equipment;
- d. Documentation of communication access needs, including live interpreting services, access to telephone devices and advanced technologies that are hearing aid compatible, and video relay service or point-to-point video, for Enrollees who are Deaf or hard of hearing;
- e. Documentation of Comprehensive Assessments, including diagnoses, prognoses, plans of care, and treatment and progress notes, signed and dated by the appropriate provider;
- f. Laboratory and radiology reports;
- g. Updates on the Enrollee's involvement and participation with community agencies that are not part of the Provider Network, including any services provided;
- h. Documentation of contacts with family members and persons giving informal support, if any;
- i. Physician orders;
- j. Enrollee's individual advance directives and health care proxy, recorded and maintained in a prominent place;

- k. Plan for Emergency Conditions and Urgent Care, including identifying information about any emergency contact persons;
 - l. Emergency psychiatric crisis plans;
 - m. Allergies and special dietary needs; and
 - n. Information that is consistent with the utilization control requirement of 42 C.F.R. 456 et. seq.
3. Coordination of Centralized Enrollee Record Information: systems must be implemented to ensure that the Centralized Enrollee Record is:
- a. Updated in a timely manner by each applicable provider of care;
 - b. Available and accessible 24 hours per day, seven days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care providers for Emergency Conditions and Urgent Care; and
 - c. Available and accessible to specialty, Long-Term Services and Supports, and mental health and substance abuse providers.
4. Confidentiality of Centralized Enrollee Record Information

The Contractor must have and comply with written policies to ensure the confidentiality of Centralized Enrollee Record information. Such policies must address the following:

- a. At a minimum, complying with all Federal and State legal requirements as they pertain to confidentiality of Enrollee records, including without limitation the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in Title 45 of the Code of Federal Regulations and Massachusetts law;
- b. Informing Enrollees how to obtain a copy of their Centralized Enrollee Records and how to request that it be amended or corrected;

- c. Requiring all First Tier, Downstream and Related Entities to abide by the confidentiality protections established by the Contractor;
- d. Ensuring that documentation of behavioral health and substance abuse treatment in the Centralized Enrollee Record includes only documentation of behavioral health assessment, diagnosis, treatment plan, therapeutic outcome or disposition, and any medications prescribed (psychotherapeutic session notes must not be recorded in the Centralized Enrollee Record);
- e. Providing records at the request of MassHealth or CMS, or both, for monitoring the quality of care provided by the Contractor in accordance with federal law (for example, 42 U.S.C. 1396a (a) (30)) and conducting performance evaluation activities; and
- f. Auditing all access to records to ensure that only authorized individuals have access to information to prevent misuse.

2.7 Provider Network

A. General

1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and EOHHS to ensure adequate access to medical, behavioral health, pharmacy, community-based services, and Long-Term Services and Supports providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health Services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206 and under this Contract (see Covered Services in **Appendix A and Appendix B**). The Contractor must notify the Contract Management Team of any significant Provider Network changes immediately, with the goal of providing notice to the Contract Management Team at least 60 days prior to the effective date of any such change.

2. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.
3. The Contractor shall make best efforts to ensure that minority-owned or controlled agencies and organizations are represented in the Provider Network. The Contractor will submit annually the appropriate certification checklist on its efforts to contract with Minority Owned Business Enterprises (see **Appendix N**).
4. In establishing and maintaining the Provider Network, the Contractor must consider the following:
 - a. The anticipated number of Enrollees;
 - b. The expected utilization of services, taking into consideration the cultural and ethnic diversity and demographic characteristics, communication requirements, and health care needs of specific Medicare-Medicaid populations enrolled with the Contractor;
 - c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;
 - d. The number of Network Providers who are not accepting new patients; and
 - e. The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.
5. The Contractor may use different reimbursement amounts for different specialties and for different practitioners in the same specialty.
6. The Contractor must demonstrate to EOHHS, including through submission of reports as may be requested by EOHHS, use of Alternative

Payment Methodologies that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. The Contractor must comply with the requirements of M.G.L. Chapter 224, Section 261 of the Acts of the 2012. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i).

- a. Alternative Payment Methodologies or methods are defined as, methods of payment that are not solely based on fee-for-service reimbursements; provided that, “alternative payment methodologies” may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements; provided further, that “alternative payment methodologies” may include fee-for-service payments, which are settled or reconciled with a bundled or global payment.
7. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et. seq.
 8. The Contractor should ensure that best efforts are made to contact out-of-network providers, including, within the first 90 days of an Enrollee’s membership in the Contractor’s plan, such providers and prescribers which are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-Network Providers. If the provider does not join the network, or if the Enrollee does not select a new in-Network Provider by the end of the 90-day period or after the Individualized Care Plan is developed, the Contractor shall choose one for the Enrollee.
 - a. The Contractor must also offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the Contractor’s Provider Network, 2) currently serving Enrollees, 3) willing to continue serving them at the Contractor in-network rate of payment, under the following circumstances:

- (1) The Contractor's network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;
 - (2) Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or
 - (3) Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.
9. If the Contractor declines to include individuals or groups of providers in its Provider Network, the Contractor must give the affected providers written notice of the reason for its decision.
10. The Contractor shall not include in its Provider Contracts any provision that directly prohibits or indirectly, through incentives or other means, limits or discourages Network Providers from participating as Network or non-network Providers in any provider network other than the Contractor's Provider Network(s).
11. The Contractor shall not establish selection policies and procedures for Providers that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
12. The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an

obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs. The Contractor's Provider Network shall include freestanding birth centers licensed by the Commonwealth of Massachusetts Department of Public Health.

13. The Contractor must demonstrate that there are sufficient Indian health care providers; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) providers in the network to ensure timely access to services available under the Contract for Indian Enrollees who are eligible to receive services from such providers.
14. The Contractor must permit any Indian who is enrolled in a non-Indian ICO and eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, to choose to receive Covered Services from that I/T/U provider, and if that I/T/U provider participates in the network as a Primary Care Provider, to choose that I/T/U as his or her Primary Care Provider, as long as that provider has capacity to provide the services.
15. At the Enrollee's request, the Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.
16. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, individuals with disabilities (both congenital and acquired disabilities), or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are Deaf, hard-of-hearing or deaf blind.
17. The Contractor shall educate providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and Federal law to communicate

with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to review at EOHHS' and CMS' discretion.

18. The Contractor shall participate in any EOHHS efforts to promote the delivery of services in a culturally competent manner to all Enrollees that is sensitive to age, gender, gender identity, sexual orientation; cultural, linguistic racial, ethnic, and religious backgrounds; and congenital or acquired disabilities.
19. The Contractor shall ensure that they contract with multilingual Network Providers to the extent that such capacity exists in the Contractor's Service Area; and ensure that all Network Providers understand and comply with their obligations under State or Federal law to assist Enrollees with skilled medical interpreters and identify the resources that are available to assist Network Providers to meet these obligations.
20. The Contractor shall ensure that Network Providers and interpreters/translators are available for those who are Deaf or hard of hearing within the Contractor's Service Area.
21. The Contractor shall ensure that its Network Providers have a strong understanding of disability culture and LTSS.

B. Provider Qualifications and Performance

1. Written Provider Protocols: The Contractor must have written protocols in the following areas:
 - a. Credentialing, re-credentialing, certification, and performance appraisal processes that demonstrate that all members of the Provider Network maintain current knowledge, ability, and expertise in the service or specialty in which they practice. Providers must meet board

certification, continuing education, and other requirements, as appropriate. The Contractor shall demonstrate to CMS and EOHHS, by reporting annually that all providers within the Contractor's Provider/Pharmacy Network are credentialed according to **Section 2.8.C** of the Contract. The protocol must also include: Enrollee Complaints and Appeals; results of quality reviews; utilization management information; and Enrollee surveys;

b. Practice guidelines, in accordance with 42 C.F.R. §438.236 and 42 C.F.R. §422.202(b);

c. Continuing education programs for ICTs, medical providers, Behavioral Health Providers, community-based service providers, and long term care providers to ensure they are knowledgeable about and sensitive to the health care needs of Enrollees. Education must also be provided about quality management activities and requirements;

d. Provider profiling activities, defined as multi-dimensional assessments of a provider's performance. The Contractor must use such measures in the evaluation and management of each component of the Provider Network. At a minimum, the Contractor must address the following:

(1) Mechanisms for detecting both underutilization and overutilization of services;

(2) Resource utilization of services, including LTSS, specialty and ancillary services;

(3) Clinical performance measures on structure, process, and outcomes of care;

(4) Interdisciplinary team performance, including resolution of service plan disagreements;

(5) Enrollee experience and perceptions of service delivery; and

(6) Timely access.

e. A revocation process or other specified remedies for providers whose performance is unacceptable in one or more of the areas noted in **Section 2.7.B.1.d.** above. For serious Complaints involving medical provider errors, the Contractor must take immediate corrective action and file reports of corrections made with CMS and MassHealth within three business days of the Complaint.

2. Primary Care Qualifications: Each Enrollee will choose or be assigned to a PCP. The PCP must be one of the following:

a. A Primary Care Physician that is

(1) Licensed by the Commonwealth;

(2) Board-certified in Family Practice, Internal Medicine, General Practice, OB/GYN, or Geriatrics; and

(3) In good standing with the federal Medicare and Federal/State Medicaid (MassHealth) program;

b. A Registered Nurse or Advanced Practice Nurse, including Nurse Practitioner, who is:

(1) Licensed by the Commonwealth; and

(2) Certified by a nationally recognized accrediting body;

c. A Physician Assistant who is licensed by the Board of Registration of Physician Assistants.

3. Subcontracting Requirements

- a. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.
- b. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. The Contractor is required to evaluate any potential contractor prior to delegation, pursuant to 42 C.F.R. § 438.20. Additional information about subcontracting requirements is contained in **Appendix D**.
- c. The Contractor must:
 - (1) Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;
 - (2) Contract only with qualified or licensed providers who continually meet federal and State requirements, as applicable, and the qualifications contained in **Appendix D**.

4. Non-Payment and Reporting of Serious Reportable Events

- a. The Contractor shall work collaboratively with EOHHS to develop and implement a process for ensuring non-payment or recovery of payment for services when "Serious Reportable Events" (SREs) (a/k/a "Never Events"), as defined by this three-way Contract, occur. The Contractor's standards for non-payment or recovery of payment shall be, to the extent feasible, consistent with the minimum standards for non-payment for such events developed by EOHHS and provided to Contractors via regulation and administrative bulletins.

- b. The Contractor shall notify EOHHS and CMS of SREs, in accordance with guidelines issued by the Department of Public Health.
 - c. The Contractor shall provide EOHHS an annual summary of SREs. Such summary shall include the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE.
5. Non-Payment and Reporting of Provider Preventable Conditions
- a. The Contractor agrees to take such action as is necessary in order for EOHHS to comply with and implement all Federal and State laws, regulations, policy guidance, and MassHealth policies and procedures relating to the identification, reporting, and non-payment of provider preventable conditions, including 42 U.S.C. 1396b-1 and regulations promulgated thereunder.
 - b. As a condition of payment, the Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:
 - (1) The Contractor shall not pay a provider for a Provider Preventable Condition.
 - (2) The Contractor shall require, as a condition of payment from the Contractor, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the Contractor and/or EOHHS.
 - (3) The Contractor shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.
 - (4) A Contractor may limit reductions in provider payments to the extent that the following apply:
 - (A) The identified Provider-Preventable Condition would otherwise result in an increase in payment.

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

(5) The Contractor shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services.

6. Non-Payment and Reporting of Preventable Hospital Readmissions

a. As directed by EOHHS, and in consultation with CMS, the Contractor shall develop and implement a process for ensuring non-payment or recovery of payment for preventable hospital readmissions. Such process shall be, to the extent feasible, consistent with minimum standards and processes developed by EOHHS.

b. The Contractor shall report all identified Provider-Preventable Conditions in a form and format specified by EOHHS within seven calendar days from occurrence.

C. Provider Profiling

1. The Contractor must conduct profiling activities for PCPs, Behavioral Health Providers, LTSS Providers, dental providers, vision providers and, as directed by EOHHS, specialty providers, at least annually. As part of its quality activities, the Contractor must document the methodology it uses to identify which and how many providers to profile and to identify measures to use for profiling such providers.

Provider profiling activities must include, but are not limited to:

- a. Developing provider-specific reports that include a multi-dimensional assessment of a provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;
- b. Establishing provider, group, or regional benchmarks for areas profiled, where applicable, including Contractor-specific benchmarks, if any;

- c. Providing feedback to providers regarding the results of their performance and the overall performance of the Provider Network; and
 - d. Designing and implementing quality improvement plans for providers who receive a relatively high denial rate for prospective, concurrent, or retrospective service authorization requests, including referral of these providers to the Network Management staff for education and technical assistance and reporting results annually to EOHHS.
2. The Contractor shall use the results of its provider profiling activities to identify areas of improvement for providers, and/or groups of providers. The Contractor shall:
- a. Establish provider-specific quality improvement goals for priority areas in which a provider or providers do not meet established Contractor standards or improvement goals;
 - b. Develop and implement incentives, which may include financial and non-financial incentives, to motivate providers to improve performance on profiled measures;
 - c. Conduct on-site visits to Network Providers for quality improvement purposes; and
 - d. At least annually, measure progress on the Provider Network and individual Providers' progress, or lack of progress, towards meeting such improvement goals.
3. The Contractor shall maintain regular, systematic reports, in a form and format approved by EOHHS, of the above-mentioned Provider profiling activities and related Quality Improvement activities pursuant to **Section 2.13**. Moreover, the Contractor shall submit to EOHHS, upon request, such reports or information that would be contained therein. The Contractor shall also submit summary results of such Provider profiling and related Quality Improvement activities as a component of its annual evaluation of the QM/QI program.

D. Provider Education and Training

The Contractor must:

1. Inform its Provider Network about its Covered Services and service delivery model;
2. Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;
3. Inform its Provider Network about the procedures and timeframes for Enrollee Complaints and Enrollee Appeals, per 42 C.F.R. § 438.414;
4. Inform its Provider Network about its quality improvement efforts and the Providers' role in such a program;
5. Inform its Provider Network about its policies and procedures, especially regarding in and out-of-network referrals;
6. Develop and provide continuing education programs for members of the Provider Network, including but not limited to:
 - a. Identification and management of depression and alcohol abuse
 - b. Identification of abuse and neglect of Enrollees;
 - c. Person-centered planning processes and cultural competency taking into consideration the specific needs of subpopulations of Enrollees;
 - d. Best practices in needs assessment, care planning and service integration;
 - e. Best practices in delivery of LTSS and other services to maximize independent living and Enrollee self-reliance;

- f. The availability and range of services, including behavioral health, community-based services, and LTSS services, available to meet Enrollee needs;
 - g. Coordination of care within the Provider Network, including instructions regarding policies and procedures for maintaining the Centralized Enrollee Record;
 - h. ADA compliance, accessibility and accommodations;
 - i. Assisting disabled Enrollees to maximize involvement and decision making in their own care;
 - j. Maximizing the independence and functioning of Enrollees with disabilities through health promotion and preventive care; and
 - k. Using mental health and substance use disorder screening tools, instruments, and procedures.
7. Instruct and assist its Provider Network in verifying each Enrollee's eligibility from the Eligibility Verification System (EVS) before providing services (except for services for Emergency Conditions), without resulting in discrimination against the Enrollee.
8. In collaboration with, and as further directed by EOHHS, the Contractor shall develop and implement quality improvement activities directed at:
- a. Ensure LTSS needs and goals are assessed, identified, and appropriately integrated with the other services provided and goals listed in the ICP;
 - b. Informing PCPs about the most effective use of the EOHHS-approved standardized behavioral health screening tools;
 - c. How to evaluate behavioral health information gathered during screenings conducted by Network Providers, such as how to evaluate the results from a behavioral health screening tool;
 - d. How and where to make referrals for follow-up behavioral health clinical and LTSS assessments and services if such referrals are necessary in the judgment of the PCP;

- e. Assisting EOHHS to improve tracking of delivered screenings, positive screenings and utilization of services by PCPs or Behavioral Health Providers following a behavioral health screening;
 - f. Improving ICT function and impact, particularly integration between primary care and behavioral health;
 - g. Promoting the development of primary care practices that operate with the capabilities of a patient-centered medical home or health home.
9. The Contractor shall provide education and training at least annually for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify behavioral health service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate.
10. EOHHS expects to convene Learning Collaboratives for Contractor staff and providers, which may include webinars, online courses, in-person sessions and other activities. The Contractor must make available key Contractor staff and contracted provider staff as requested by EOHHS and CMS to attend these learning opportunities.

2.8 Network Management

A. General Requirements

The Contractor shall:

1. Develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, the principles of rehabilitation and recovery for Behavioral Health Services, the Independent Living Philosophy, Cultural

Competence, integration and cost effectiveness. The management strategy shall address all providers. Such strategy shall include at a minimum:

- a. A system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;
 - b. A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals;
 - c. Conducting on-site visits to Network Providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and
 - d. Ensuring that its Provider Network is adequate to assure access to all Covered Services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services;
2. Establish and conduct an ongoing process for enrolling in their Provider Network any willing and qualified provider that meets the Contractor's requirements and with whom mutually acceptable Provider Contract terms, including with respect to rates, are reached.
 3. Operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the beneficiary's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's PBM during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its plans' Service Areas are open, (e.g., contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

- a. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.
 - b. Eighty (80) percent of incoming calls answered within thirty (30) seconds.
 - c. Disconnect rate of all incoming calls not to exceed five (5) percent.
4. Maintain and distribute a Provider Manual(s), which includes specific information about Covered Services, non-covered services, and other requirements of the Contract relevant to Provider responsibilities. The Contractor shall submit an updated Provider Manual(s) to EOHHS and CMS annually and such updated Provider Manual(s) shall be distributed to providers annually and made available to providers on the Contractor's website; provided, however, after initial submission, if there are no substantial changes to the Provider Manual in a given year, then the Contractor is not required to submit a copy to EOHHS but shall certify to EOHHS that there are no substantial changes.

The Provider Manual(s) shall include, but not be limited to, the following information:

- a. Enrollee rights and the requirement that Enrollees must be allowed to exercise such rights without having their treatment adversely affected;
- b. Provider responsibilities, as a member of the ICT;
- c. That Enrollees may file a Grievance with the Contractor if the provider violates any Enrollee rights and the steps the Contractor may take to address any such Grievances;
- d. Enrollee Privacy matters;
- e. Provider responsibility for assisting Enrollees with interpreter services;

- f. Provider obligation to accept and treat all Enrollees regardless of race/ethnicity, age, English proficiency, gender identity, sexual orientation, health status, or disability;
- g. General rules of Provider-Enrollee communications;
- h. Covered Services lists;
- i. Provider obligation to make Enrollees aware of available clinical options and all available care options;
- j. Permissible Provider marketing activities;
- k. Providers may not charge Enrollees or the Contractor for any service that (a) is not a Medically Necessary Covered Service or non-covered service; (b) for which there may be other Covered Services or non-covered services that are available to meet the Enrollee's needs; and (c) where the provider did not explain items (a) and (b) and (c), that the Enrollee will not be liable to pay the Provider for the provision of any such services. The provider shall be required to document compliance with this provision;
- l. Information on advance directives, as defined in 42 C.F.R. § 489.100, and pursuant to 42 C.F.R. § 422.108;
- m. The Contractor's authority to audit the presence of advance directives in medical records;
- n. Services that need PCP referrals or prior authorization;
- o. Full explanation of new Enrollee's right to the initial continuity-of-care period;
- p. Enrollee rights to access and correct medical records information;
- q. The process through which the Contractor communicates updates to policies (for Providers and First tier, Downstream and Related Entities);
- r. Timelines for rendering decisions on service authorizations and frequency of concurrent reviews;
- s. The process and timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

- t. Protocols for transitioning Enrollees from one Behavioral Health Provider to another;
 - u. Protocols for communication and coordination between members of the Enrollee's ICT, including access to electronic health records or care management portals;
 - v. Coordination between Behavioral Health Providers and PCPs;
 - w. Coordination between Behavioral Health Providers and State agencies, including but not limited to DDS, DMH, Department of Transitional Assistance (DTA), Department of Corrections (DOC), Probation and Parole;
 - x. Provider responsibility for submission of Notification of Birth forms;
 - y. Steps a provider must take to request disenrollment of an Enrollee from his/her panel;
 - z. Information on the Contractor's administrative Appeals process;
 - aa. Information on the Contractor's process for an internal Appeal following an Adverse Action, including an Enrollee's right to use a provider as an Appeal representative; and
 - bb. Information on the policy against balance billing.
5. Maintain a protocol that shall facilitate communication to and from providers and the Contractor, and which shall include, but not be limited to, a provider newsletter and periodic provider meetings;
 6. Except as otherwise required or authorized by CMS, EOHHS or by operation of law, ensure that providers receive 30 days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and
 7. Work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Goals and all other requirements of this Contract.

B. Proximity Access Requirements

The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>));
2. For Medicare pharmacy providers, time, distance and minimum number as required in **Appendix F**, Article II, Section I and 42 C.F.R. §423.120; or
3. Within a 15-mile or 30 minute radius from the Enrollee's ZIP code of residence:
 - a. At least two PCPs;
 - b. Two hospitals (when feasible); and
 - c. Two nursing facilities, except that with CMS and EOHHS prior approval, Contractor may offer Enrollee only one nursing facility.
4. In addition, the Contractor must demonstrate annually that its Provider Network has sufficient providers to ensure that each Enrollee has a choice of at least two outpatient Behavioral Health Providers and two community LTSS Providers per Covered Service as listed in **Appendix A** that are either within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence, except that with EOHHS prior approval, Contractor

may offer Enrollee only one community LTSS Provider per Covered Service.

C. Provider Credentialing, Recredentialing, and Board Certification

1. General Provider Credentialing

The Contractor shall:

- a. Implement written policies and procedures that comply with the requirements of 42 C.F.R. §§422.504(i)(4)(iv) and 438.214(b) regarding the selection, retention and exclusion of providers and meet, at a minimum, the requirements below. The Contractor shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually that all providers within the Contractor's Provider Network are credentialed according to such policies and procedures. The Contractor shall:
 - (1) Designate and describe the departments(s) and person(s) at the Contractor's organization who will be responsible for provider credentialing and re-credentialing;
 - (2) Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13;
 - (3) Ensure that all providers are credentialed prior to becoming Network Providers and that a site visit is conducted with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations;

- (4) Maintain a documented re-credentialing process which shall occur at least every three years (thirty six months) and shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews utilization management information, and Enrollee satisfaction surveys;
- (5) Maintain a documented re-credentialing process that requires that physician Providers and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards such as those provided by NCQA and relevant State regulations, when obtaining Continuing Medical Education (CME) credits or continuing Education Units (CEUs) and participating in other training opportunities, as appropriate;
- (6) Upon notice from EOHHS, not authorize any providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:
 - (A) The Contractor shall, at a minimum, check the BORIM website at least twice per month for its Providers and check the Board of Registration in Dentistry (BORID), OIG List of Excluded Individuals Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) (the successor to the Excluded Parties List System (EPLS)) for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing;
 - (B) If a provider is terminated or suspended from MassHealth, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the Contractor shall terminate, suspend, or decline a provider from its Network as appropriate.
 - (C) The Contractor shall notify CMS and EOHHS, via the contract management team, when it terminates, suspends, or declines a provider from its Network because of fraud, integrity, or quality; and

(D) On an annual basis, the Contractor shall submit to EOHHS a certification checklist that it has implemented the actions necessary to comply with this section.

- b. Not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished, directed or prescribed by, a provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and 1001.1901; furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person)
- c. Not establish provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
- d. Ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;
- e. Search and do not contract with the names of parties disclosed during the credentialing process in the BORIM, BORID, OIG LEIE, MED, and SAM exclusion or debarment databases and the MassHealth exclusion list, and parties that have been terminated from participation under Medicare or another state's Medicaid program;
- f. Obtain disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. 1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to EOHHS in accordance with this Contract, including this

Section 2.8.H.1, and relevant state and federal laws and regulations;
and

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

2. Board Certification Requirements

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

- a. Require that all applicant physicians be board certified in their practicing medical specialty, or are in the process of achieving initial certification as a condition for participation, except as otherwise set forth in below;
- b. Except as otherwise set forth below, require that all participating physicians achieve board certification in a time frame relevant to the guidelines established by their respective medical specialty boards, as applicable;
- c. If necessary to ensure adequate access, the Contractor may contract with providers who have training consistent with board eligibility but are not board certified. In such circumstances, the Contractor shall submit to EOHHS for review and approval, on a case-by-case basis, documentation describing the access need that the Contractor is trying to address; and
- d. Provide a mechanism to monitor participating physician compliance with the Contractor's board certification requirements, including, but not limited to, participating physicians who do not achieve board certification within the applicable time frames.

3. Behavioral Health Provider Credentialing

In addition to those requirements described above, the Contractor shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of Behavioral Health Providers. The Contractor shall:

- a. Implement the Behavioral Health Credentialing Criteria as prior approved by EOHHS;
- b. Meet or exceed all of the requirements of this Contract with regard to Behavioral Health Credentialing Criteria and Behavioral Health Clinical Criteria;
- c. For Behavioral Health providers treating substance use disorders, the Contractor must require these providers to report to it on CEU trainings they have participated in on substance use disorder;
- d. For a BH Services Provider that is a hospital that provides Behavioral Health Inpatient Services, ensure that such hospital has a human rights protocol that is consistent with the DMH requirements to this Contract and includes training of the Behavioral Health Provider's staff and education for Enrollees regarding human rights; and
- e. For a BH Services Provider that is a hospital that provides Behavioral Health Inpatient Services, ensure that such hospital has a human rights officer who shall be overseen by a human rights committee, and shall provide written materials to Enrollees regarding their human rights.

D. Primary Care Provider (PCP) Network

- 1. The Contractor shall make best efforts to ensure that PCP turnover does not exceed 7% annually. The Contractor shall monitor and annually report to EOHHS the number and rate of PCP turnover separately for those PCPs who leave the Contractor's Plan voluntarily and those PCPs who are terminated by the Contractor. If the Contractor's annual PCP turnover rate exceeds 7%, the Contractor shall submit an explanation for the turnover rate to EOHHS. EOHHS may subsequently request a business plan addressing the turnover rate for EOHHS review and approval.
- 2. The Contractor shall monitor Enrollees' voluntary changes in PCPs to identify Enrollees with multiple and frequent changes in PCPs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long term patient-doctor relationship with one's PCP, and to recommend to the PCP that a screen for the need for any Behavioral Health Services may be indicated, including situations where the Contractor suspects drug seeking behavior.

E. Family Planning Provider Network

The Contractor cannot restrict the choice of the provider from whom the Enrollee may receive family planning services and supplies. The Contractor must provide or arrange family planning services as follows:

1. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services;
2. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the ICO network;
3. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to:
4. All methods of contraception, including sterilization, vasectomy, and emergency contraception;
 - a. Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and
 - b. Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination; and
5. Comply with the requirements of 42 C.F.R. § 441.202 and the Abortion Services Contract between EOHHS and the Contractor.

F. Behavioral Health Network Requirements

1. Substance Use Disorder Treatment Providers
 - a. To the extent permitted by law, the Contractor shall require all substance use disorder treatment Providers to submit to DPH/BSAS the data required by DPH.
 - b. The Contractor shall require all substance use disorder treatment Providers to track, by referral source:
 - (1) All referrals for services;

- (2) The outcome of each referral (i.e., admission, etc.); and
- (3) If the substance use disorder treatment Provider refuses to accept a referral, the reason for the refusal.

2. State-Operated Community Mental Health Centers (SOCMHCs)

The Contractor shall refer cases to the SOCMHCs in a manner that is consistent with the policies and procedures for Network referrals generally.

3. Emergency Services Programs (ESPs)

The Contractor must maintain relationships execute and maintain contracts with the Emergency Services Program (ESP) providers that are located within the Contractor's Service Area to provide ESP services.

- a. The Contractor must execute and maintain contracts with ESPs that are not run by the Department of Mental Health.
- b. If the Contractor does not contract with ESPs operated by DMH, the Contractor shall coordinate admissions and triage with DMH ESPs as it would with any contracted ESP.
- c. The Contractor must include the ESPs serving members in each county where the Contractor operates in its Behavioral Health Provider Network as part of the Covered Services for Behavioral health in **Appendix A**. The Contractor will contract with the ESPs according to the established Performance Specifications that currently exist for MassHealth-only members.

4. The Contractor must contract with hospitals operated by the DMH and the DPH.

G. Long Term Services and Supports Provider Network

The Contractor's Provider Network must offer a selection of nursing facility and community long term services and supports providers that meets Enrollee needs and preferences and satisfies the time and distance requirements at **Section 2.8** above.

H. Personal Assistance Services Network

1. ICO must meet Personal Assistance Services (PAS) network requirements.
 - a. For intake and orientation, skills training, development of Service Agreements, and assessment of the Member's ability to manage Self-directed PCA Services independently:
 - b. ICOs must contract with Personal Care Management (PCM) Agencies that are under contract with EOHHS to provide PCM Services to Enrollees accessing Self-directed PCA Services.
 - c. Enrollees who are authorized to receive Self-directed PCA Services at the time of enrollment with the ICO must be granted the option of continuing to receive their PCM Services through their current PCM provider, to ensure continuity of Self-directed PCA Services.
 - d. Enrollees who are not authorized to receive Self-directed PCA Services at the time of enrollment must be offered a choice of at least two PCM Agencies, at least one of which must be an Independent Living Center (ILC) operating as a PCM where geographically feasible. Enrollees over the age of 60 must be offered the option of receiving PCM Services through an Aging Services Access Point (ASAP) operating as a PCM.
2. Fiscal Intermediary (FI) Services:

- a. Enrollees who are authorized to receive Self-directed PCA Services at the time of enrollment with the ICO must have the option to continue to receive their FI services through their current FI. Enrollees who are not authorized to receive Self-directed PCA Services at the time of enrollment with the ICO will elect a PCM Agency. The PCM Agency is responsible for electing a single FI to serve all their Consumers.

3. PAS Evaluations:

- a. ICOs must ensure that PAS evaluations are done in a timely manner to ensure appropriateness and continuity of services.
- b. ICOs may contract with PCM Agencies under contract with EOHHS to perform evaluations for PAS Services.
- c. ICOs that do not contract with ILCs for PAS evaluations must provide and require training for their PAS evaluators on the Independent Living Philosophy.

4. Promoting Self-Direction of Services:

- a. ICOs must provide information, choice and needed supports to promote self-direction of PAS by Enrollees. ICOs must inform Enrollees that they may identify a surrogate to help them if they choose Self-directed PCA Services.
- b. ICOs must pay for services rendered by the PCA hired by the Enrollee if the PCA meets MassHealth requirements in 130 CMR 422.411 (A)(1) and has completed the required FI paperwork. The ICO must pay the FI the PCA rate as set by the Division of Health Care and Finance

Policy under 114.3 CMR 9.00, which includes both the PCA collective bargaining wage, payment for employer required taxes, and workers' compensation insurance.

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

5. PAS Services for Enrollees who do not choose Self-directed PCA: The Contractor must provide Enrollees who do not choose Self-directed PCA, or who are not able to find a surrogate to assist them to self-direct, with the option of having their PAS provided by an agency. ICOs must contract with such agencies, and provide Enrollees with the choice of at least two PAS agency providers, except that with EOHHS prior approval, Contractor may offer Enrollee only one PAS agency provider. Services provided by PAS agency providers must be person-centered and the Enrollee must have a choice of the schedule for PCAs and of who provides PAS.

2.9 Enrollee Access to Services

A. General

1. The Contractor must provide services to Enrollees as follows:
 - a. Authorize, arrange, coordinate and provide to Enrollees all Medically Necessary Covered Services as specified in **Section 2.4, Appendix A** and **Appendix B**, in accordance with the requirements of the Contract;

 - b. Offer adequate choice and availability of primacy, specialty, acute care, behavioral health and long term services and support providers that meet CMS and EOHHS standards as provided in **Section 2.8.B**;

c. Reasonably accommodate persons and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The Contractor and its Network Providers must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. The Contractor shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the Contractor by:

(1) Providing flexibility in scheduling to accommodate the needs of the Enrollees;

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

(A) Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;

(B) Ensuring that all written materials are available in formats compatible with optical recognition software;

(C) Reading notices and other written materials to individuals upon request;

(D) Assisting individuals in filling out forms over the telephone;

- (E) Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

 - (F) TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified American Sign Language interpreters for the Deaf; and

 - (G) Individualized forms of assistance;
- (3) Ensuring safe and appropriate physical access to buildings, services and equipment;

 - (4) Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility,, documenting any deficiencies in compliance and monitoring correction of deficiencies;

 - (5) The Contractor must identify to EOHHS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The ICO must also establish and execute, and annually update a work plan to achieve and maintain ADA compliance;

 - (6) When a PCP or any medical, behavioral health or Long-Term Services and Supports provider is terminated from the Contractor's plan or leaves the network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within 15 days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or Long-Term Services and Supports

provider. For terminations of PCPs, the Contractor must also report the termination to EOHHS and provide assistance to the Enrollee in selecting a new PCP within 15 calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or Long-Term Services and Supports, the Contractor shall ensure that there is no disruption in services provided to the Enrollee; and

- (7) When the Food and Drug Administration (FDA) determines a drug to be unsafe, the Contractor will remove it from the formulary immediately. The Contractor must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within 5 days after the removal, to each Enrollee with a current or previous prescription for the drug. The Contractor must also make a good faith effort to call, within 3 calendar days, each Enrollee with a current or previous prescription for the drug; a good faith effort must involve no fewer than three phone call attempts at different times of day.
 - (8) If the Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.
 - (9) The Contractor shall annually report on its use of out-of-network providers to meet Enrollee's necessary medical service needs.
- d. Have the capacity to meet the needs of the linguistic groups in its Service Area. The following must be available:
- (1) The provision of care, including 24-hour telephone access and scheduling appointments, by providers who are fluent in both

English and the language spoken by the Enrollee, or through translation services performed by individuals who are:

(A) Trained to translate in a medical setting;

(B) Fluent in English; and

(C) Fluent in the Enrollee's language;

(2) Linguistically appropriate pharmacy, specialty, behavioral health, and Long-Term Services and Supports.

e. If a pharmacist cannot bill Contractor at the time an Enrollee presents the pharmacy provider with a prescription for a MassHealth covered medication and in accordance with 130 CMR 406.414(c), the pharmacy provider charges MassHealth for a one-time 72 hour supply of prescribed medications, the Contractor shall reimburse MassHealth for any such sums. EOHHS shall perform quarterly one-time medication supply reconciliations as follows. EOHHS shall:

(1) Calculate all claims paid by EOHHS for one-time 72 hour supplies of prescribed medications provided to Enrollees each quarter; and

(2) Deduct the amount of such claims paid from a future capitation payment to the Contractor after written notification to the Contractor of the amount and timing of such deduction.

f. Ensure access to Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that Network Providers are aware of and comply with such laws so that physical and

communication barriers do not inhibit Enrollees from obtaining services under the Contract;

- g. Ensure that non-English speaking Enrollees have a choice of at least two PCPs, and at least two Behavioral Health Providers within each behavioral health covered service category, in the Prevalent Language in the region provided that such provider capacity exists within the region.

B. Provider Availability

1. The Contractor must provide a 24-hours-per-day, 7-days-per-week toll-free system with access to a registered nurse who:
 - a. Has immediate access to the Centralized Enrollee Record (see **Section 2.6.F**);
 - b. Is able to respond to Enrollee questions about health or medical concerns;
 - c. Has the experience and knowledge to provide clinical triage;
 - d. Is able to provide options other than waiting until business hours or going to the emergency room; and
 - e. Is able to provide access to oral interpretation services available as needed, free-of-charge.
2. The Contractor must follow Federal and State regulations about 24-hour service availability (for example, hospital, home health, and hospice require 24-hour availability; adult day health, homemaker, and chore services do not).

3. The Contractor's provider network must ensure access to 24-hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. The Contractor must:
 - a. Have a process established to notify the PCP or ICT (or the designated covering physician) of an Emergency Condition within one business day after the Contractor is notified by the provider. If the Contractor is not notified by the provider within 10 calendar days of the Enrollee's presentation for Emergency Services, the Contractor may not refuse to cover Emergency Services.
 - b. Have a process to notify the PCP or ICT of required Urgent Care within 24 hours of the Contractor being notified.
 - c. Record summary information about Emergency Conditions and Urgent Care services in the Centralized Enrollee Record no more than 18 hours after the PCP or ICT is notified, and a full report of the services provided within two business days.
 - d. Pay the provider or reimburse the Enrollee, in the fee-for-service amount that would have been paid by Medicare or MassHealth, if services are obtained out of network for Emergency Conditions. This must be done within 60 calendar days after the claim has been submitted. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.
 - e. The Contractor may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracted providers at least the lower of: 1) the amount that the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. § 412.105(g) and 42 C.F.R. § 413.76 for section 1861(u) providers) or 2) the provider's charges as permitted under 42 C.F.R. 422.214. Such payments shall be in accordance with 42 U.S.C. 1395w-22(a)(2) 1395w-22(k)(1), and 1395cc(a)(1)(O). This requirement applies regardless of the setting and type of care for authorized out-of-network services. Nothing in the preceding provision shall restrict the right of the provider and the Contractor to negotiate a lower rate of payment.

- f. Cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. 438.114(c). The Contractor may not deny payment for treatment obtained when an enrollee had an Emergency Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. 438.114(a) of the definition of emergency medical condition.
 - g. Ensure that an Enrollee who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - h. The Contractor may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
 - i. The Contractor may not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in Section 1861(o)(7) of the Act
 - j. Additions to Medicaid required services enacted through legislative or judicial change, including mid-year updates, will not require a Contract revision or agreement by all parties prior to the Contractor offering providing or arranging for the service to Enrollees.
4. The Contractor's provider network must comply with the Emergency Medical Treatment and Labor Act (EMTALA), which requires;
- a. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. 489.24(b).
 - b. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

- c. The Contractor's contracts with its providers must clearly state the provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
5. The Contractor Provider Network must ensure availability of office visits as follows;
- a. All Urgent Care and symptomatic office visits must be available to Enrollees within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention. Examples include recurrent headaches or fatigue.
 - b. Except as described in Section 2.9.B.5.c below, all nonsymptomatic office visits must be available to Enrollees within 30 calendar days. Examples of nonsymptomatic office visits include, but are not limited to well and preventive-care visits for Covered Services, such as annual physical examinations or immunizations. (See **Appendix A and B** for a list of Covered Services.)
 - c. Office visits must be available within the following timeframes to Enrollees for Behavioral Health Services Other Than Emergency Services, ESP, or Urgent Care
 - (1) All Other Behavioral Health Services: within 14 calendar days.
 - (2) For services described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:
 - (A) Non-24-Hour Diversionary Services – within two calendar days of discharge;
 - (B) An appointment to review and refill medications – within 14 calendar days of discharge; and

(C) Other outpatient services – within seven calendar days of discharge;

6. The Contractor's provider network must ensure availability of Long Term Services and Supports as follows;
 - a. Provider Network must offer a selection of nursing facility and community long term services and supports providers that meets Enrollee needs and preferences and satisfies the proximity requirements of this Contract.
7. The Contractor must demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the Enrollee's place of residence when office visits are unsafe or inappropriate for the Enrollee's clinical status. Service sites must include, but not be limited to the Enrollee's private residence, a nursing or assisted-living facility, and day care programs.
8. The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or MassHealth Fee-For-Service if the Provider serves only Enrollees or other persons eligible for MassHealth.
9. The Contractor may request an exception to the access standards set forth in this **Section 2.9** by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to, or more permissive than, the usual and customary community standards for accessing care. Upon approval by EOHHS, in consultation with CMS, the Contractor shall notify Enrollees in writing of such alternative access standards.
10. The Contractor shall have a system in place to monitor and document access and appointment scheduling standards. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/access standards specified above in **Section 2.9** and shall

promptly address any access deficiencies. Annually, in accordance with **Appendix N**, the Contractor shall evaluate and report to EOHHS Network-wide compliance with the access standards specified in **Section 2.9**.

C. Services Not Subject to Prior Approval

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

1. Any services for Emergency Conditions as defined in 42 C.F.R 422.113(b)(1) and 438.114(a) (which includes emergency Behavioral Health care);
2. Urgent Care sought outside of the Service Area;
3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical Provider is unavailable or inaccessible;
4. Family planning services;
5. Out-of-area renal dialysis services;
6. Prescription drugs as required in **Appendix F**;
7. Effective October 1, 2015:

- a. Inpatient Substance Use Disorder Services (Level IV) as defined in **Appendix B**, Exhibit 1. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee;
- b. Acute Treatment Services for Substance Use Disorders (Level III.7) (ATS), as defined in **Appendix B**, Exhibit 2. The Contractor shall require providers delivering ATS to provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the Enrollee, information regarding the Enrollee's coverage with the Contractor, and the provider's initial treatment plan. Contractor may not use failure to provide such notice as the basis for denying claims for services provided. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee;
- c. Clinical Support Services for Substance Use Disorders (Level III.5) (CSS), as defined in **Appendix B**, Exhibit 2. The Contractor shall require providers delivering CSS to provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the Enrollee, information regarding the Enrollee's coverage with the Contractor, and the provider's initial treatment plan. Contractor may not use failure to provide such notice as the basis for denying claims for services provided. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee;
- d. Outpatient Services for covered substance use disorder treatment services: The following Behavioral Health Outpatient Services, as defined in **Appendix B**, Exhibit 1: Couples/Family Treatment, Group Treatment, Individual Treatment, and Ambulatory Detoxification (Level II.d);
- e. Day Treatment: Structured Outpatient Addiction Program (SOAP), as defined in **Appendix B**, Exhibit 2;
- f. Intensive Outpatient Program (IOP), as defined in **Appendix B**, Exhibit 2; and
- g. Partial Hospitalization, as defined in **Appendix B**, Exhibit 2, for American Society of Addiction Level 2.5, with short-term day or evening mental health programming available five (5) to seven (7) days per week.

8. Effective November 15, 2015:

- a. The initiation or re-initiation of a buprenorphine/naloxone prescription of 32 mg/day or less, for either brand formulations (e.g. Suboxone™, Zubsolv™, Bunavail™) or generic formulations, provided, however, that the Contractor may have a preferred formulation. Contractor may establish review protocols for continuing prescriptions. Notwithstanding the foregoing, the Contractor may implement prior authorization for buprenorphine (Subutex™) and limit coverage to pregnant or lactating women and individuals allergic to naloxone, provided such limitations are clinically appropriate.”

D. Authorization of Services

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

1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:
 - a. Have in place and follow written policies and procedures;
 - b. Have in place procedures to allow managed care enrollees to initiate requests for provisions of services;
 - c. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and
 - d. Consult with the requesting Provider when appropriate.
2. The Contractor shall ensure that a Primary Care Provider and a Behavioral Health Provider are available 24 hours a day for timely authorization of Medically Necessary Services and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor’s Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS.

3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health Services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health Services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.
4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.
5. The Contractor shall authorize PAS to meet Enrollees' needs for assistance with ADLs and IADLs. The Contractor may consider the Enrollee's need for physical assistance as well as cueing or monitoring in order for the Enrollee to perform an ADL or IADL. Authorizations must consider the medical and independent living needs of the Enrollee.
6. The Contractor must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 5.1, and must:
 - a. Be produced in a manner, format, and language that can be easily understood;
 - b. Be made available in Prevalent Languages, upon request; and

- c. Include information, in the most commonly used languages about how to request translation services and Alternative Formats. Alternative Formats shall include materials which can be understood by persons with limited English proficiency.

- 7. The Contractor must make authorization decisions in the following timeframes:
 - a. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than 14 calendar days after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:
 - (1) The Enrollee or the Provider requests an extension, or

 - (2) The Contractor can justify (to the satisfaction of EOHHS and/or CMS upon request) that:
 - (A) The extension is in the Enrollee's interest; and

 - (B) There is a need for additional information where:
 - i. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

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

 - b. For expedited service authorization decisions, where the Provider indicates or the Contractor determines that following the standard timeframe in **Section 2.9.D.7.a above** could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and

no later than 72 hours after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:

- (1) The Enrollee or the Provider requests an extension; or
- (2) The Contractor can justify (to EOHHS and/or CMS upon request) that:
 - (A) The extension is in the Enrollee's interest; and
 - (B) There is a need for additional information where:
 - i. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
 - ii. Such outstanding information is reasonably expected to be received within 14 calendar days.
- c. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the ICO must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

E. Utilization Management

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

1. Staffing of all Utilization Management activities shall include, but not be limited to, a Medical Director, or Medical Director's designee. The Contractor shall also have a Medical Director's designee for Behavioral Health Utilization Management. All of the team members shall:

- a. Be in compliance with all federal, State, and local professional licensing requirements;
 - b. Include representatives from appropriate specialty areas. Such specialty areas shall include, at a minimum, cardiology, epidemiology, OB/GYN, psychiatry, and substance use disorders;
 - c. Have at least two or more years of experience in managed care or peer review activities, or both;
 - d. Not have had any disciplinary actions or other type of sanction ever taken against them, in any state or territory, by the relevant professional licensing or oversight board or the Medicare and Medicaid programs; and
 - e. Not have any legal sanctions relating to his or her professional practice including, but not limited to, malpractice actions resulting in entry of judgment against him or her, unless otherwise agreed to by EOHHS.
2. In addition to the requirements set forth in **Section 2.9.D.1**, the Medical Director's designee for Behavioral Health Utilization Management shall also:
 - a. Be board-certified or board-eligible in psychiatry; and
 - b. Be available 24 hours per day, seven days a week for consultation and decision-making with the Contractor's clinical staff and Providers.
 3. The Contractor shall have in place policies and procedures that at a minimum:
 - a. Routinely assess the effectiveness and the efficiency of the Utilization Management program;
 - b. Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and technology, Behavioral Health treatments, pharmacy formularies and devices;
 - c. Target areas of suspected inappropriate service utilization;
 - d. Detect over- and under-utilization;

- e. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;
 - f. Compare Enrollee and Provider utilization with norms for comparable individuals and Network Providers;
 - g. Routinely monitor inpatient admissions, emergency room use, ancillary, out-of-area services, and out-of-network services, as well as Behavioral Health Inpatient and Outpatient Services, Diversionary Services, and ESPs;
 - h. Ensure that treatment and Discharge Planning are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other Providers, and other supports identified by the Enrollee as appropriate;
 - i. Conduct retrospective reviews of the medical records of selected cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care;
 - j. Refer suspected cases of Provider or Enrollee Fraud or Abuse to EOHHS;
 - k. Address processes through which the Contractor monitors issues around services access and quality identified by the ICO, EOHHS, Enrollees, and Providers, including the tracking of these issues and resolutions over time; and
 - l. Are communicated, accessible, and understandable to internal and external individuals, and entities, as appropriate.
4. The Contractor's Utilization Management activities shall include:
- a. Referrals and coordination of Covered Services;
 - b. Authorization of Covered Services, including modification or denial of requests for such services;
 - c. Assisting Providers to effectively provide inpatient Discharge Planning;
 - d. Behavioral Health treatment and Discharge Planning;
 - e. Monitoring and assuring the appropriate utilization of specialty services, including Behavioral Health Services;
 - f. Providing training and supervision to the Contractor's Utilization Management clinical staff and Providers on:
 - (1) The standard application of Medical Necessity criteria and Utilization Management policies and procedures to ensure that staff maintain and improve their clinical skills;

- (2) Utilization Management policies, practices and data reported to the ICO to ensure that it is standardized across all Providers within the ICO's Provider Network; and
 - (3) The consistent application and implementation of the Contractor's Clinical Criteria and guidelines including the Behavioral Health Clinical Criteria approved by EOHHS.
- g. Monitoring and assessing all Contractor services and outcomes measurement, using any standardized clinical outcomes measurement tools to support Utilization Management activities; and
 - h. Care management programs.
5. Ensure that clinicians conducting Utilization Management who are coordinating Behavioral Health Services, and making Behavioral Health service authorization decisions, have training and experience in the specific area of Behavioral Health service for which they are coordinating and authorizing Behavioral Health Services. The Contractor shall ensure the following:
 - a. That the clinician coordinating and authorizing mental health services shall be a clinician with experience and training in mental health services;
 - b. That the clinician coordinating and authorizing substance use disorders shall be a clinician with experience and training in substance use disorders; and
 - c. That the clinician coordinating and authorizing services for Enrollees with Co-Occurring Disorders shall have experience and training in Co-Occurring Disorders.
 6. The Contractor shall have policies and procedures for its approach to retrospective utilization review of Providers. Such approach shall include a system to identify utilization patterns of all Providers by significant data elements and established outlier criteria for all services.
 7. The Contractor shall have policies and procedures for conducting retrospective and peer reviews of a sample of Providers to ensure that the services furnished by Providers were provided to Enrollees, were appropriate and Medically Necessary, and were authorized and billed in accordance with the ICO's requirements.
 8. The Contractor shall have policies and procedures for conducting monthly reviews of a random sample of no fewer than 500 Enrollees to ensure that such Enrollees received the services for which Providers billed with respect to such Enrollees; and shall report the results of such review to EOHHS as requested.

9. The Contractor shall not provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.
10. Submit an annual report of Enrollees who have been enrolled in the Contractor's Plan for one year or more with no utilization. The report shall include an explanation of outreach activities to engage these Enrollees.
11. Effective October 1, 2015, if utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level III.5), such activities may be performed no earlier than day 7 of the provision of such services, provided, however, that the Contractor may not make any utilization review decisions that impose any restriction or deny any future medically necessary clinical stabilization services unless an Enrollee has received at least 14 consecutive days of clinical stabilization services. Any such decisions must follow the requirements set forth in Section 2.12 regarding the transmission of adverse determination notifications to Enrollees and clinicians and processes for internal and external appeals of Contractor's decisions.
12. Effective October 1, 2015, the Contractor may not impose concurrent review and deny coverage for ATS based on utilization review; however, the Contractor may contact providers of ATS to discuss coordination of care, treatment plans, and after care.
13. Effective October 1, 2015, the Contractor may not establish utilization management strategies that require enrollees to "fail-first" or participate in "step therapy" as a condition of providing coverage for injectable naltrexone (Vivitrol™). Contractor must cover Vivitrol™ as a pharmacy and medical benefit."

F. Behavioral Health Service Authorization Policies and Procedures

The Contractor shall:

1. Review and update annually, at a minimum, the Behavioral Health Clinical Criteria and other clinical protocols that the ICO may develop and utilize in its review and submit any modifications to EOHHS annually for review and approval. In its review and update process, the Contractor shall consult with its clinical staff or medical consultants outside of the Contractor's organization, or both, who are familiar with standards and practices of mental health and substance use treatment in Massachusetts.

2. Review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health Services authorization policies and procedures.
3. Develop and maintain Behavioral Health Inpatient Services and Diversionary Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:
 - a. If prior authorization is required for any Behavioral Health Inpatient Services admission or Diversionary Service, assure the availability of such prior authorization 24 hours a day, seven days a week;
 - b. A plan and a system in place to direct Enrollees to the least intensive but clinically appropriate service;
 - c. A system to provide an initial authorization and communicate the initial authorized length of stay to the Enrollee, facility, and attending physician for all Behavioral Health emergency inpatient admissions verbally within 30 minutes, and within two hours for non-emergency inpatient authorization and in writing within 24 hours of admission;
 - d. Processes to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed;
 - e. A system to concurrently review Behavioral Health Inpatient Services to monitor Medical Necessity for the need for continued stay, and achievement of Behavioral Health Inpatient Services treatment goals;
 - f. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans and Diversionary Services treatment plans; and
 - g. Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP and other providers, such as community-based mental health services providers, as appropriate;
4. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:
 - a. Policies and procedures to automatically authorize at least 12 Behavioral Health Outpatient Services;
 - b. Policies and procedures for the authorization of all Behavioral Health Outpatient Services beyond the initial 12 Outpatient Services;

- c. Policies and procedures to authorize Behavioral Health Outpatient Services based upon Behavioral Health Clinical Criteria; and
- d. Policies and procedures based upon Behavioral Health Clinical Criteria; to review and approve or deny all requests for Behavioral Health Outpatient Services based on Clinical Criteria.

G. Coordinating Access for Emergency Conditions and Urgent Care Services

The Contractor must ensure linkages among the ICT, and any appropriate acute, LTSS, pharmacy or Behavioral Health Providers to keep all parties informed about utilization of services for Emergency Medical Conditions and Urgent Care.

H. Authorization of LTSS, Expanded Services, and Community-based Services

1. At a minimum, the Contractor's authorizations of LTSS listed in **Appendix B, Exhibit 1**, must comply with MassHealth FFS authorization criteria for those Covered Services.
2. The Contractor must develop authorization criteria and a process for authorizing the expansions of PCA and DME services listed in **Appendix B, Exhibit 3** that considers the Enrollee's entire ICP. The Contractor has the discretion to authorize such services in a determined amount, duration and scope for an Enrollee, if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care and institutional long-term care.
3. The Contractor must develop authorization criteria and a process for authorizing the Community-based Services listed in **Appendix B, Exhibit 4**, that considers the Enrollee's entire ICP. The Contractor has the discretion to authorize such services in a determined amount, duration and scope for an Enrollee if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting and with

reduced reliance on emergency department use, acute inpatient care and institutional long-term care.

4. The Contractor has discretion to cover other community-based services not listed in **Appendix B** if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care, considering the Enrollee's entire ICP. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care and institutional long-term care.

I. Services for Specific Populations

Each Contractor shall:

1. At the direction of EOHHS, actively participate in initiatives, processes and activities of EOHHS agencies with which specific Enrollees have an affiliation, including but not limited to care coordination and other activities described in **Section 2.5.H**. Such agencies include, but are not limited to:
 - a. The Department of Developmental Services (DDS);
 - b. The Department of Mental Health (DMH);
 - c. The Department of Public Health and DPH's Bureau of Substance Abuse Services (DPH/BSAS);
 - d. The Massachusetts Commission for the Blind (MCB);
 - e. The Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH);
 - f. The Massachusetts Rehabilitation Commission (MRC); and
 - g. The Executive Office of Elder Affairs (EOEA).
2. Deliver preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.
3. Deliver prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.
4. Provide family planning services as follows:

- a. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services;
 - b. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the ICO network; and
 - c. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to:
 - (1) All methods of contraception, including sterilization, vasectomy, and emergency contraception;
 - (2) Counseling regarding HIV, sexually transmitted diseases, and risk reduction practices; and
 - (3) Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, or pregnancy termination.
5. Provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing fully integrated delivery system, the Contractor shall respect the privacy of Enrollees. The Contractor shall comply with **Section 5.2** regarding compliance with laws and regulations relating to confidentiality and privacy.

J. Emergency and Post-stabilization Care Coverage

1. The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor. The Contractor shall pay a non-contracted provider of Emergency and Post-stabilization Care or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at an amount equal to or, if the Contractor can negotiate a lower payment, less than the amount the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare or Medicaid FFS, or if a lesser amount, the providers charge for that service. The original Medicare payment amounts for section 1861(u) providers do not include payments under 42 C.F.R. § 412.105(g) and 42 C.F.R. § 413.76. The Contractor shall ensure that the Enrollee is not

billed for the difference, if any, between such rate and the non-contracted provider's charges.

2. The Contractor shall not deny payment for treatment for an Emergency Condition, pursuant to 42 C.F.R. § 438.114, and as provided for in **Section 2.9.B.3.e**, above.
3. The Contractor shall not deny payment for Emergency Services if a representative of the Contractor instructed the Enrollee to seek Emergency Services.
4. The Contractor shall not limit what constitutes an Emergency Condition on the basis of lists of diagnoses or symptoms.
5. The Contractor shall require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.
6. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge.
7. The ICO shall cover and pay for Post-stabilization Care Services in accordance with 42 C.F.R. § 438.114(e), 42 C.F.R. § 422.113(c), and M.G.L. c. 118E, § 17A.

K. Notification of Birth and Coverage of Newborns

The Contractor shall:

1. In the form and format provided by EOHHS, submit to EOHHS by close of business each Friday the Notification of Pregnancy file. EOHHS shall use the file to track the eligibility and enrollment of an Enrollee who the Contractor determines is pregnant.
2. Facilitate immediate transfer of newborns to the MassHealth eligibility process. The Contractor will not be responsible for costs associated with newborns on or after the date of birth as they will be retroactively enrolled in the MassHealth program effective the date of birth as soon as practicable.

3. For all births to Enrollees, require the Provider that delivered the newborn, such as the hospital, to submit a properly completed Notification of Birth (NoB) form to MassHealth's Notification of Birth Unit. Such form shall be submitted by the Provider to MassHealth within 30 calendar days of the newborn's date of birth. The Contractor shall include such requirement in its Provider Contracts.
4. Collaborate with EOHHS to establish a smooth and efficient process for reporting all newborns.

2.10 Enrollee Services

A. Enrollee Service Representatives (ESRs)

The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Eligible Beneficiaries, consistent with the requirements of 42 C.F.R. § 422.111(h) and 423.128(d) as well as the following requirements:

1. Be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;
2. Be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;
3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service;
4. Inform callers that interpreter services are free;
5. Be knowledgeable about MassHealth, Medicare, and the terms of the Contract, including the Covered Services listed in **Appendix A**;

6. Be available to Enrollees to discuss and provide assistance with resolving Enrollee Complaints;
7. Have access to the Contractor's enrollee database, EOHHS's Eligibility Verification System (EVS), and an electronic provider directory;
8. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including American Sign Language (ASL);
9. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;
10. Demonstrate sensitivity to culture, including disability culture and the Independent Living Philosophy;
11. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of grade 6 and below, and individualized guidance from Enrollee Services Representatives to ensure materials are understood;
12. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the ICO;
13. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and
14. Ensure that Enrollee Services Representatives make available to Enrollees and Eligible Beneficiaries, upon request, information concerning the following:
 - a. The identity, locations, qualifications, and availability of Providers;
 - b. Enrollees' rights and responsibilities;
 - c. The procedures available to an Enrollee and Provider(s) to challenge or appeal the failure of the ICO to provide a Covered Service and to appeal any Adverse Actions (denials);
 - d. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats;
 - e. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

- f. The procedures for an Enrollee to change plans or to opt out of the Demonstration; and
- g. Additional information that may be required by Enrollees and Eligible Beneficiaries to understand the requirements and benefits of the ICO.

B. Enrollee Service Telephone Responsiveness

1. The Contractor must operate a call center during normal business hours, 7 days a week, consistent with the required Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance. ESRs must be available Monday through Friday, during normal business hours, consistent with the required Medicare Marketing Guidelines, the Medicare-Medicaid marketing guidance, and the Massachusetts State-specific Marketing guidance. The Contractor may use alternative call center technologies on Saturdays, Sundays, and Federal holidays.
2. The Contractor's ESRs must answer 80% of all Enrollee telephone calls within 30 seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five (5) percent. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

C. Coverage Determinations and Appeals Call Center Requirements

1. The Contractor must operate a toll-free call center with live customer service representatives available to respond to providers or Enrollees for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call centers. The call centers must operate during normal business hours as specified in the Medicare Marketing Guidelines, the Medicare-Medicaid marketing guidance and the

Massachusetts state specific Marketing guidance. The Contractor must accept requests for Medicare or Medicaid coverage, including Medicare coverage determinations / redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

- a. Indicates that the mailbox is secure;
- b. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the member is making an expedited or standard request);
- c. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and
- d. For Appeals calls, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and 30 calendar days for standard Appeal requests.

D. Consumer Advisory Board

1. The Contractor shall establish a consumer advisory board or include MMP consumers on a pre-existing governance board that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the consumer advisory board:
 - a. Meets at least quarterly throughout the Demonstration.
 - b. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and MassHealth reserve the right to review and approve consumer membership.
 - c. Reports annually:
 - 1) The dates for all meetings held within the reporting year;

- 2) Names of board members invited;
 - 3) Names of board members in attendance;
 - 4) Names of board members invited who are actual beneficiaries or family caregivers;
 - 5) Names of board members in attendance who are actual beneficiaries or family caregivers;
 - 6) Meeting agenda; and
 - 7) Meeting minutes.
2. The Contractor shall also include Ombudsperson reports, as available, in quarterly updates to the consumer advisory board.
 3. The Contractor shall participate in all statewide stakeholder and oversight meetings as requested by MassHealth and/or CMS.

2.11 Enrollee Grievance

A. Grievance Filing

The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page. 422.504(b)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

B. Grievance Administration

1. Internal (plan level) Grievance

An Enrollee may file an Internal Enrollee Grievance at any time with the ICO or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. The Contractor must maintain written records of all Grievance activities, and notify CMS and MassHealth of all internal Grievances. The system must meet the following standards:

- a. Timely acknowledgement of receipt of each Enrollee Grievance;
- b. Timely review of each Enrollee Grievance;
- c. Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than 30 days after the Contractor receives the Grievance;
- d. Expedited response, orally or in writing, within 24 hours after the Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and
- e. Availability to Enrollees of information about Enrollee Appeals, as described in **Section 2.12**, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2. External Grievance

The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page. 422.504(b)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

External Grievances filed with MassHealth shall be forwarded to the Contract Management Team and entered into the CMS Complaints tracking module, which will be accessible to the Contractor.

2.12 Enrollee Appeals

A. General

1. All Contractors shall utilize and all Enrollees may access the existing Medicare Part D Appeals Process, as described in **Appendix F**. Consistent with existing rules, Part D Appeals will be automatically forwarded to the IRE if the Contractor misses the applicable adjudication timeframe. The Contractor must maintain written records of all Appeal activities, and notify CMS and MassHealth of all internal Appeals.

2. Integrated/Unified Non-Part D Appeals Process Overview:

a. Notice of Action – In accordance with 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Action. Such notice shall be provided at least 10 days in advance of the date of its action, in accordance with 42 C.F.R. §438.404. An Enrollee or a provider acting on behalf of an Enrollee and with the Enrollee’s written consent may appeal the Contractor’s decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §438.402 and 42 C.F.R. §422.574, an Enrollee or provider action on behalf of an Enrollee and with the Enrollee’s consent may also appeal the Contractor’s delay in providing or arranging for a Covered Service.

3. Appeal time frames - As more fully detailed below, Enrollees, and/or their providers, or their authorized Appeal representatives will have 60 days to file an Appeal related to coverage and benefits.

a. The Contractor shall acknowledge receipt of each Appeal and notify EOHHS of Board of Hearings Appeals daily.

4. Appeal levels

a. Initial Appeals (first level internal Appeal) will be filed with the Contractor.

b. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE) by the Contractor.

c. Subsequent Appeals for services covered by MassHealth only (e.g. Personal Assistance Services, Behavioral Health Diversionary Services, dental services, LTSS, and MassHealth-covered drugs excluded from Medicare Part D) may be appealed to the MassHealth Board of Hearings (Board of Hearings) after the initial plan-level Appeal has been completed.

d. Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the Contractor, and an Enrollee may also file a request for a hearing with the Board of Hearings. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

5. Part D Appeals may not be filed with the Board of Hearings.

6. Appeals related to drugs excluded from Part D that are covered by MassHealth must be filed with the Board of Hearings.

7. Appeal resolution time frames - All service Appeals must be resolved (at each level) within 30 days of their submission for standard Appeals in accordance with Section 2.12.B.3 and within 72 hours of their submission for expedited Appeals in accordance with Section 2.12.B.4.

8. Continuing Services Pending an Appeal - The Contractor must provide Continuing Services for all prior approved non-Part D benefits that are terminated or modified pending internal Contractor Appeals, per timeframes in 42 C.F.R. §438.420. This means that such benefits will continue to be provided by providers to Enrollees and that the Contractors must continue to pay providers for providing such services or benefits pending an internal Appeal.

9. For all Appeals filed with the Board of Hearings, an Enrollee may request Continuing Services. MassHealth will make a determination on continuation of services in accordance with the Commonwealth's existing Appeals policy at 130 CMR §610.036, in accordance with 42 C.F.R. §438.420.

10. The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the Appeal was pending and the Contractor, or the MassHealth Board of Hearings officer reverses a decision to deny, limit, or delay services.

11. Integrated Notice - Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice for each of the internal and external Appeals processes. The form and content of the notice must be prior approved by CMS and EOHHS. The Contractor shall notify the Enrollee of any Adverse Action at least 10 days in advance of the date of its action.

a. The notice must explain:

- (1) The action the Contractor has taken or intends to take;
- (2) The reasons for the action;

- (3) The citation to the regulations supporting such action;
- (4) The Enrollee's or the provider's right to file an Appeal;
- (5) Procedures for exercising Enrollee's rights to Appeal, including where an Enrollee can file an Appeal (at the IRE, Board of Hearings or both specifically applicable to the Contractor's action);
- (6) Circumstances under which expedited resolution is available and how to request it; and
- (7) If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal.

b. The notice must:

- (1) Use easily understood language and format, and be available in Alternative Formats that meet the accessibility needs of Enrollees. All Enrollees and Eligible Beneficiaries must be informed that information is available in Alternative Formats and how to access those formats;
- (2) Be translated for the individuals who speak Prevalent Languages; and
- (3) Include language clarifying that oral interpretation is available for all languages and how to access it.

B. Internal (Plan-level) Appeals

1. Filing an Internal Appeal

- a. If the Enrollee disagrees with the Contractor's decision, the Enrollee may file an internal Appeal by writing, faxing, or calling the

Contractor within 60 calendar days of the receipt of the written denial notice. Any oral request for a hearing must be documented in writing. A provider acting on behalf of an Enrollee, or an authorized representative acting on behalf of an enrollee with the Enrollee's written consent, may file an internal Appeal. This does not affect any Appeal rights that such provider has under Subpart M of 42 C.F.R. Part 422. An Enrollee must first exhaust the Contractor's internal Appeal process before the Enrollee can proceed with an external Appeal.

- b. The Contractor shall acknowledge receipt of each Appeal.
- c. The Contractor must allow the Enrollee and/or a designated representative an opportunity, before and during the Appeals process, to examine the Enrollee's case file, including medical records, and any other documents and records; and consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.
- d. The Contractor must ensure that oral inquiries seeking to appeal an action, including an expedited Appeal, are treated as Appeals and confirm those requests in writing, unless the enrollee or the provider requests expedited resolution.

2. Making an Internal Appeal Decision

The Contractor must make an internal Appeal decision within 30 days. The Contractor must afford a reasonable opportunity for the Enrollee, or a designated representative, to present information orally or in writing during the internal Appeal process. The internal Appeal decision must be made by a physician or other appropriate provider who was not involved in the initial decision and who has appropriate expertise in the field for the services at issue. The Contractor must notify the Enrollee of its internal Appeal decision in writing and, for an expedited internal Appeal, the Contractor must also make reasonable efforts to provide oral notice.

The written notice must include the elements outlined in **Section 2.12.A.11** above.

3. Standard Internal Appeal Process

a. The Contractor must notify the Enrollee of the internal Appeal decision as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the Contractor's receipt of the Appeal. The Contractor may extend this time frame up to 14 calendar days if the Enrollee requests the extension or if the Contractor justifies the need for additional information and how the extension of time benefits the Enrollee. When the Contractor takes an extension, the Enrollee must be notified in writing.

b. If the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health requires, but no later than 30 calendar days after the Contractor's receipt of the internal Appeal (or no later than the expiration of an extension).

4. Expedited Internal Appeal Process

a. The Enrollee or their authorized representative has the right to request, orally or in writing, and receive an expedited Appeal decision affecting the Enrollee's treatment in a time-sensitive situation. The Enrollee must ask for an expedited 72-hour review when the Appeal request is made. The Enrollee need not use the words "expedited" when making the request for an urgent or fast action. The Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution. The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

b. If the Contractor decides, based on medical criteria, that the Enrollee's situation is time-sensitive, or if any physician or other provider of an Enrollee's services makes the request for the Enrollee or

calls or writes in support of the request for an expedited review, the Contractor must issue a decision as expeditiously as the Enrollee's health requires, but no later than 72 hours after receiving the request. The Contractor may extend this time frame by up to 14 calendar days if the Enrollee requests the extension or if the Contractor justifies the need for additional information and how the extension of time benefits the Enrollee. For any extension not requested by the Enrollee, the Contractor must give the Enrollee written notice of the reason for the delay. The Contractor must make a decision as expeditiously as the Enrollee's health requires, but no later than the end of any extension period.

c. If the Contractor determines not to give the Enrollee an expedited Appeal, the Contractor must give the Enrollee prompt verbal notice followed by written confirmation within two calendar days that the Appeal will be decided within the time frame for a standard Appeal (30 calendar days).

d. If, on expedited Appeal, the Contractor decides fully in the Enrollee's favor, the Contractor must provide or authorize the requested service as expeditiously as the Enrollee's health condition requires but no later than 72 hours after the Contractor's receipt of the Appeal (or no later than upon expiration of an extension discussed above).

C. External Appeals

1. The CMS Independent Review Entity (IRE)

a. If, on internal Appeal, the Contractor does not decide fully in the Enrollee's favor within the relevant time frame, the Contractor shall automatically forward the case file regarding Medicare services to the CMS IRE for a new and impartial review. The IRE is contracted by CMS.

For standard external Appeals, the IRE will send the Enrollee and the Contractor a letter with its decision within 30 calendar days after it

receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

b. The CMS IRE must apply both the Medicare and MassHealth (which shall be considered supplemental services) definition for Medically Necessary Services when adjudicating the Enrollee's Appeal for Medicare and supplemental services, and must decide based on whichever definition, or combination of definitions, provides a more favorable decision for the Enrollee.

c. If the CMS IRE decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision.

d. For expedited external Appeals, the CMS IRE will send the Enrollee and the Contractor a letter with its decision within 72 hours after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

e. If the Contractor or the Enrollee disagrees with the IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The Contractor must comply with any requests for information or participation from such further Appeal entities.

2. The MassHealth Board of Hearings

All MassHealth benefits, behavioral health diversionary services, and community-based services may be also appealed to the MassHealth Board of Hearings after the initial plan-level Appeal discussed above.

a. Whenever the Contractor sends notification to an Enrollee or his or her representative (or the representative of a deceased Enrollee's estate) of its service decision, the Contractor must include information on filing a Board of Hearings Appeal, including notice that the Enrollee, his or her representative, or the representative of a deceased Enrollee's estate have standing to be a party in the hearing. The form and content of the notification used by the Contractor must be prior approved by EOHHS and CMS. The Enrollee must submit any request

for a Board of Hearings Appeal, in writing, no later than 30 calendar days from the date of mailing of the Contractor's internal appeal decision.

- b. Whenever an Enrollee submits a written request for a Board of Hearings Appeal within 10 calendar days of the date of mailing of the Contractor's internal Appeal decision, the Contractor is responsible for the provision of Continuing Services, if so requested by the Enrollee during the pendency of a Board of Hearings Appeal.
 - c. If the Board of Hearings decides in the Enrollee's favor, the Contractor must authorize or provide the service in dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice of the Board of Hearings decision.
 - d. If the Contractor or the Enrollee disagrees with the BOH decision, there are further levels of Appeal available, including judicial review of the decision under M.G.L. c. 30A. The Contractor must comply with any final decision upon judicial review.
 - e. The Contractor must designate an appeal coordinator to act as a liaison between the Contractor and Board of Hearings.
3. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

D. Hospital Discharge Appeals

1. When an Enrollee is being discharged from the hospital, the Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.
2. The Enrollee has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. Such a request must be made by noon of the first workday after the receipt of the notice.

3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The Contractor must ensure that the Enrollee receives the *Detailed Notice of Discharge (CMS-10066)*. Note: an Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.
4. The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.
5. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.
6. If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

E. Other Discharge Appeals

1. The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facilities, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.13 Quality Improvement Program

A. Quality Improvement (QI) Program

The Contractor shall:

1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:
 - a. Quality of physical health care, including primary and specialty care;
 - b. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;
 - c. Quality of long term services and supports (LTSS);
 - d. Adequate access and availability to primary, behavioral health care, specialty health care, pharmacy, and LTSS providers and services;
 - e. Continuity and coordination of care across all care and services settings, and for transitions in care; and
 - f. Enrollee experience and access to high quality, coordinated, and culturally competent clinical care and services, inclusive of LTSS across the care continuum.
2. Apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:
 - a. Quantitative and qualitative data collection and data-driven decision-making;
 - b. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
 - c. Feedback provided by Enrollees and Network Providers in the design, planning, and implementation of its CQI activities; and
 - d. Issues identified by the Contractor, EOHHS and/or CMS; and
3. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health Services, community-based services, and LTSS.

B. QI Program Structure

1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

2. The Contractor shall:
 - a. Establish a set of QI functions and responsibilities that are clearly defined and proportionate to, and adequate for, the planned number and types of QI initiatives to ensure completion of QI initiatives in a competent and timely manner;
 - b. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;
 - c. Seek the input of providers and medical professionals representing the composition of the Contractor's provider network in developing functions and activities;
 - d. Establish internal processes to ensure that the QM activities for Primary, specialty, and Behavioral Health Services, community-based services, and LTSS reflect utilization across the Network and include all of the activities in this Section 2.13 of this Contract and, in addition, the following elements:
 - (1) A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;
 - (2) A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling

method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to EOHHS;

- (3) A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the Contractor's Plan. The Contractor shall submit a survey plan to EOHHS for approval and shall submit the results of the survey to EOHHS and CMS;
 - (4) A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;
 - (5) A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in Consumer advisory boards; and
 - (6) In collaboration with and as further directed by EOHHS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.
- e. Have in place, and submit to EOHHS and CMS annually, a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall:
- (1) Address all aspects of health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;
 - (2) Address the roles of the designated physician(s), behavioral health clinician(s), community-based service providers, and LTSS providers with respect to QI program;
 - (3) Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and
 - (4) Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management;

- f. In the first Demonstration Year, submit to EOHHS and CMS a QI Work Plan that shall include the following components or other components as directed by EOHHS and CMS:
 - (1) Planned clinical and non-clinical initiatives;
 - (2) The objectives for planned clinical and non-clinical initiatives;
 - (3) The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;
 - (4) The individual(s) responsible for each clinical and non-clinical initiative;
 - (5) Any issues identified by the Contractor, EOHHS, Enrollees, and Providers, and how those issues are tracked and resolved over time;
 - (6) Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and
 - (7) Process for correcting deficiencies.

- g. Evaluate the results of QI initiatives at least annually, and submit an updated QI work plan with the results of the evaluation to the EOHHS QM manager and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

- h. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include:
 - (1) At least one designated physician, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a professional with expertise in the assessment

and delivery of long term services and supports with substantial involvement in the QI program;

(2) A qualified individual to serve as the QI Director who will be directly accountable to the Contractor's contract manager or equivalent position, and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the Plan's executive leadership team. This individual shall be responsible for:

(A) Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

(B) Maintaining an active role in the Contractor's overall QI structure;

(C) Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

i. Physical and behavioral health care;

ii. Pharmacy management;

iii. Care management;

iv. Long-term Services and Supports;

v. Financial;

vi. Statistical/analytical;

vii. Information systems;

viii. Marketing, publications;

ix. Enrollment; and

x. Operations management;

i. Actively participating in, or assigning staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by EOHHS, or an

EOHHS Contractor, that may be attended by representatives of EOHHS, an EOHHS Contractor, MassHealth-contracted ICOs, and other entities, as appropriate; and

- j. Serving as liaison to, and maintaining regular communication with, EOHHS QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

C. QI Activities

1. Performance Measurement

The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §422.516(a) and §423.514 for Parts C and D, respectively.

Measurement and improvement projects shall be conducted in accordance with requirements in the Memorandum of Understanding between CMS and the Commonwealth of Massachusetts of August 22, 2012 (MOU), **Figure 7-1** Core Quality Measures, and as described in this Contract, and shall include, but are not limited to:

- a. All HEDIS, Health Outcomes Survey (HOS) and CAHPS data, as well as all other measures listed in **Figure 7-1** Core Quality Measures of the MOU referenced above (**Figure 7-1**). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.
- b. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by EOHHS and CMS, as follows:
 - (1) Collect and submit to EOHHS, CMS and/or CMS' contractors, in a timely manner, data for the measures listed in **Figure 7-1**;

- (2) Contribute to all applicable EOHHS and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS;
 - (3) Contribute to EOHHS and CMS data regarding the individual and aggregate performance of MassHealth-contracted ICOs with respect to the noted measures; and
 - (4) Contribute to EOHHS processes culminating in the publication of any additional technical or other reports by EOHHS related to the noted measures.
- c. The Contractor shall demonstrate how to utilize results of the measures listed in **Figure 7-1** in designing QI initiatives.
2. Member Experience Surveys (MES)
- a. The Contractor shall conduct member experience survey activities, as directed by EOHHS and/or CMS, as follows:
 - b. Conduct, as directed by EOHHS and CMS, an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;
 - c. Conduct, as directed by EOHHS, the HCBS Experience survey for individuals utilizing LTSS during the prior calendar year. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;
 - d. Conduct, as directed by EOHHS, a quality of life survey, such as the Young and Bullock 2003 survey, adapted for general populations. This survey may be self-administered, or administered by a trained interviewer;
 - e. Contribute, as directed by EOHHS and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by EOHHS and CMS and rectifying those inadequacies, as directed by EOHHS and CMS;
 - f. Contribute, as directed by EOHHS, to processes culminating in the development of an annual report by EOHHS regarding the individual and aggregate MES performance of MassHealth-contracted ICOs; and

- g. The Contractor shall demonstrate best efforts to utilize member experience survey results in designing QI initiatives.

3. Quality Improvement Project Requirements

The Contractor shall implement and adhere to all processes relating to the Quality Improvement Project Requirements, as directed by EOHHS and CMS and as specified in **Appendix E**, as follows:

- a. In accordance with 42 C.F.R. §438.240 (d) and 42 C.F.R. §422.152 (d), collect information and data in accordance with Quality Improvement Project Requirement specifications for its Enrollees; using the format and submission guidelines specified by EOHHS and CMS in annual guidance provided for the upcoming contract year;
- b. Implement the quality improvement project requirements, in a culturally competent manner, to achieve objectives as specified in **Appendix E**;
- c. Evaluate the effectiveness of quality improvement interventions;
- d. Plan and initiate processes to sustain achievements and continue improvements;
- e. Submit to EOHHS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by EOHHS and CMS. Such reports shall include information regarding progress on Quality Improvement Project Requirements, barriers encountered and new knowledge gained. As directed by EOHHS and CMS, the Contractor shall present this information to EOHHS and CMS at the end of the quality improvement requirement project cycle as determined by EOHHS and CMS; and
- f. In accordance with 42 C.F.R. §422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, EOHHS and CMS may require them to address specific topic areas.

D. CMS-Specified Performance Measurement and Performance Improvement Projects

The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

E. External Quality Review (EQR) Activities

1. The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS and the Quality Improvement Organization (QIO) to conduct External Quality Review (EQR) Activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR Activities shall include, but are not limited to:
 - a. Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;
 - b. Annual validation of performance improvement projects required by EOHHS and CMS; and
 - c. At least once every three years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees.
2. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR Activities including, but not limited to:
 - a. Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:
 - (1) Oversee and be accountable for compliance with all aspects of the EQR activity;
 - (2) Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO, QIO, EOHHS and/or CMS staff in a timely manner;
 - (3) Serve as the liaison to the EQRO, QIO EOHHS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and EOHHS in a timely manner; and
 - (4) Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR Activity and as requested by the EQRO, QIO, CMS or EOHHS.

- b. Maintaining data and other documentation necessary for completion of EQR Activities specified above. The Contractor shall maintain such documentation for a minimum of seven years;
- c. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or EOHHS;
- d. Participating in ICO-specific and cross-ICO meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;
- e. Implementing actions, as directed by EOHHS and/or CMS, to address recommendations for quality improvement made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, EOHHS, and CMS in subsequent years; and
- f. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by EOHHS and CMS.

F. QI for Utilization Management Activities

The Contractor shall utilize QI to ensure that it maintains a well-structured Utilization Management (UM) program that supports the application of fair, impartial and consistent UM determinations. The QI activities for the UM Program shall include:

- 1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;
- 2. At least one designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one designated Behavioral Health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of long term services and supports representative of the Contractor or subcontractor, with substantial involvement in the UM program; and
- 3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the

UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

G. Clinical Practice Guidelines

The Contractor shall:

1. Adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:
 - a. Are based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of long term services and supports in the relevant field, community-based support services or the Contractor's approved behavioral health performance specifications and Clinical Criteria;
 - b. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of long term services and supports;
 - c. Do not contradict existing Massachusetts-promulgated guidelines as published by the Department of Public Health, the Department of Mental Health, or other State agencies;
 - d. Prior to adoption, have been reviewed by the Contractor's Medical Director, as well as other ICO practitioners and Network Providers, as appropriate; and
 - e. Are reviewed and updated, as appropriate, or at least every two years.
2. Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care and LTSS professionals and providers;
3. For guidelines that have been in effect two years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;
4. Disseminate, in a timely manner, the clinical guidelines to all new Network Providers, to all affected Providers, upon adoption and revision,

and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's Web site. The Contractor shall notify Providers of the availability and location of the guidelines, and shall notify Providers whenever changes are made;

5. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across Utilization Management decisions and Enrollee education; and
6. Submit to EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

H. QI Workgroups

1. As directed by EOHHS, the Contractor shall actively participate in QI workgroups that are led by EOHHS, including any Quality Management workgroups or activities, attended by representatives of EOHHS, MassHealth-contracted ICOs, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

2. EOHHS-Directed Performance Incentive Program

EOHHS and CMS will require that the Contractor meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in **Section 4.3.D**. In order to receive any withhold payments, the Contractor shall comply with all EOHHS and CMS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

3. Enrollee Incentives

The Contractor may implement Enrollee Incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits, Wellness Initiatives). The Contractor shall:

- a. Take measures to monitor the effectiveness of such Enrollee incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;
- b. Ensure that the nominal value of Enrollee incentives do not exceed \$30; and

- c. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Enrollee incentives and assure that all such Enrollee incentives comply with all applicable Medicare-Medicaid marketing guidance, as well as state and federal laws.
4. Behavioral Health Services Outcomes
- a. The Contractor shall require Behavioral Health Providers to measure and collect clinical outcomes data, to incorporate that data in treatment planning and within the medical record, and to make clinical outcomes data available to the Contractor, upon request;
 - b. The Contractor's Behavioral Health Provider contracts shall require the Provider to make available Behavioral Health Clinical Assessment and outcomes data for quality management and Network Management purposes;
 - c. The Contractor shall use outcome measures based on behavioral health care best practices. As directed by EOHHS, the Contractor shall collaborate with Behavioral Health Providers to develop outcome measures that are specific to each Behavioral Health Service type. Such outcome measures may include:
 - (1) Recidivism;
 - (2) Adverse occurrences;
 - (3) Treatment drop-out;
 - (4) Length of time between admissions; and
 - (5) Treatment goals achieved.
5. External Audit/Accreditation Results

The Contractor shall inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to EOHHS, at the direction of EOHHS, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any.

6. Health Information System

The Contractor shall maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QI Program.

2.14 Marketing, Outreach, and Enrollee Communications Standards

A. General Marketing, Outreach, and Enrollee Communications Requirements

1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under section 1851(h) of the Social Security Act; 42 C.F.R. §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines as updated from time to time, with the following exceptions or modifications:
 - a. The Contractor must refer Enrollees and Eligible Beneficiaries who inquire about Capitated Financial Alignment Model eligibility or enrollment to the enrollment broker, although the Contractor may provide Enrollees and Eligible Beneficiaries with factual information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the enrollment broker;
 - b. The Contractor must make available to CMS and EOHHS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Eligible Beneficiaries;
 - c. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically

accessible to all Enrollees or Eligible Beneficiaries, including persons with disabilities and persons using public transportation.

- d. The Contractor may not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible Beneficiaries to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor;
- e. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts (with the exception of direct mail, which is permissible);
- f. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:
 - (1) the recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;
 - (2) the Contractor is endorsed by CMS, Medicare, Medicaid, the Federal government, EOHHS, or similar entity; and
- g. Annually, the Contractor shall present its marketing plan to EOHHS for review and approval.

B. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

- 1. Made available in Alternative Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;
3. Translated into Prevalent Languages;
4. Sent in Spanish to members whose primary language is known to be Spanish, if the materials are pre-enrollment or enrollment materials; and
5. Mailed with a multi-language insert that indicates that the Enrollee can access free interpreter services to answer any questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines provisions on the multi-language insert, as well as the following additional languages: Italian, Arabic, German, Korean, Tagalog, French, French Creole, Polish, Hindi, Japanese, Cambodian, Haitian Creole, and Laotian.

C. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

1. The Contractor must receive prior approval of all marketing and Enrollee Communications materials in categories of materials that CMS and EOHHS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and EOHHS. CMS and EOHHS may agree to defer to one or the other party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.
2. CMS and EOHHS may conduct additional types of review of Contractor Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

- a. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.
- b. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.
- c. "For cause" review of materials and activities when Complaints are made by any source, and CMS or EOHHS determine it is appropriate to investigate.
- d. "Secret shopper" activities where CMS or EOHHS request Contractor materials, such as enrollment packets.

3. Beginning of Marketing, Outreach, and Enrollee Communications Activity

The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to new Enrollees more than 90 days prior to the effective date of enrollment for the following Contract year.

D. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

1. Consistent with the timelines specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance, the Contractor must provide new Enrollees with the following materials which, with the exception of the material specified in paragraph (d) below, must also be provided annually thereafter:
 - a. An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. 423.128; includes information about all Covered

Services, as outlined below, and that uses the model document developed by CMS and EOHHS.

- (1) Enrollee rights (see **Appendix B**);

- (2) An explanation of the Centralized Enrollee Record and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

- (3) How to obtain a copy of the Enrollee's Centralized Enrollee Record;

- (4) How to obtain access to specialty, behavioral health, pharmacy and Long-Term Services and Supports providers;

- (5) How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:
 - (A) What constitutes emergency medical condition, Emergency Services, and Post-stabilization Services, with reference to the definitions in 438.114(a);

 - (B) The fact that prior authorization is not required for Emergency Services;

 - (C) The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

(D) The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-stabilization Services covered under the Contract;

(E) That the Enrollee has a right to use any hospital or other setting for emergency care; and

(F) The Post-stabilization Care Services rules at 422.113(c).

(6) Information about advance directives (at a minimum those required in 42 C.F.R. 489.102 and 42 C.F.R. 422.128), including Enrollee rights under the law of the Commonwealth; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience; that Complaints concerning noncompliance with the advance directive requirements may be filed with EOHHS; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee;

(7) How to obtain assistance from ESRs;

(8) How to file Grievances and Internal and External Appeals, including:

(A) Grievance, Appeal and fair hearing procedures and timeframes;

(B) Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

(C) A statement that when requested by the Enrollee, benefits will continue at the plan level for all benefits, and if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, and the Enrollee may be required to pay to EOHHS the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee; and

- (9) How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;
- (10) How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as EOHHS or CMS may identify, including an Ombudsperson;
- (11) The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;
- (12) How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing in accordance with 42 C.F.R. § 447.50 through 42 C.F.R. § 447.60, and how transportation is provided;
- (13) How to change providers; and
- (14) How to disenroll voluntarily.

b. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and uses the

model document developed by CMS and the Commonwealth. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for individuals enrolled through Passive Enrollment. For current Enrollees, the SB must be sent with the Annual Notice of Change as described in the Medicare-Medicaid marketing guidance.

- c. A combined provider and pharmacy directory that is consistent with the requirements in **Section 2.14**, or a separate notice on how to access this information online and how to request a hard copy.
 - d. A single identification (ID) card for accessing all Covered Services under the plan that uses the model document developed by CMS and the Commonwealth;
 - e. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the Commonwealth's outpatient prescription drug benefit and that uses the model document developed by CMS and the Commonwealth.
 - f. The procedures for an Enrollee to change ICOs or to opt out of the Demonstration.
2. The Contractor must provide the following materials to current Enrollees on an ongoing basis:
 - a. An Annual Notice of Change that summarizes all major changes to the Contractor's covered benefits from one contract year to the next, and that uses the model document developed by CMS and the Commonwealth.
 - b. As needed to replace old versions or upon an Enrollee's request, a single identification (ID) card for accessing all Covered Services under the plan;
 3. The Contractor must provide all Medicare Part D required notices, with the exception of the LIS Rider, the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late

enrollment penalty notices required under Chapter 13 of the Prescription Drug Benefit Manual.

4. Consistent with the requirement at 42 C.F.R. §423.120(b)(5), the Contractor must provide Enrollees with at least 60 days advance notice regarding changes to the comprehensive, integrated formulary.
5. The Contractor must ensure that all information provided to Enrollees and Eligible Beneficiaries (and families when appropriate) is provided in a manner and format that is easily understood and that is:
 - a. Made available in large print (at least 16 point font) to Enrollees as an Alternative Format, upon request;
 - b. For vital materials, available in Prevalent Languages, as provided for in the Medicare-Medicaid marketing guidance;
 - c. Written with cultural sensitivity and at a sixth grade reading level or below; and
 - d. Available in Alternative Formats, according to the needs of Enrollees and Eligible Beneficiaries, including Braille, oral interpretation services in non-English languages, as specified in **Section 2.3 and Section 2.14.B** of this Contract; audiotape; American Sign Language video clips, and other alternative media, as requested.

E. Provider/Pharmacy Network Directory

1. Maintenance and Distribution

The Contractor must:

- a. Maintain a combined Provider/Pharmacy Network directory that uses the model document developed by CMS and MassHealth;
- b. Provide either a copy or a separate notice on how to access the information online and how to request a hard copy, as specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance, to all new enrollees at the time of enrollment and annually thereafter;
- c. When there is a significant change to the network, the Contractor must send a special mailing, as specified in the Medicare Marketing Guidelines and the Medicare-Medicaid marketing guidance;
- d. Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. § 422.111(h) and 42 C.F.R. § 423.128(d);
- e. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty calendar days before the termination effective date to all members who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all members who are patients of that primary care professional must be notified; and
- f. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.

2. Content of Provider/Pharmacy Network Directory

- a. The Provider/Pharmacy Network directory must include, at a minimum, the following information for all providers in the Contractor's Provider Network:
 - (1) The names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).
 - (2) As applicable, network Providers with training in and experience treating:

(A) Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

(B) Homeless persons;

(C) Persons who are Deaf or hard-of-hearing and blind or visually impaired;

(D) Persons with co-occurring disorders; and

(E) Other specialties.

(3) For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

(4) As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

(5) For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, licensing information, such as license number or National Provider Identifier;

(6) Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment.

(7) Whether the Provider is accepting new patients as of the date of publication of the directory;

- (8) Whether the Network Provider is on a public transportation route;
 - (9) Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;
 - (10) As applicable, whether the Network Provider has access to language line interpreters;
 - (11) For Behavioral Health Providers, training in and experience treating trauma, child welfare, and substance use;

 - (12) A description of the roles of the PCP and Interdisciplinary Care Team (ICT) and the process by which Enrollees select and change PCPs.
- b. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:
- (1) The names, addresses, telephone numbers of all current pharmacies; and
 - (2) Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line (as described in **Section 2.10**) for assistance in finding a convenient pharmacy, including one that is linguistically accessible.

2.15 Financial Requirements

A. Financial Viability

1. Minimum Net Worth

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

a. Throughout the term of this Contract, the Contractor must maintain a minimum net worth of \$1,500,000, subject to the following conditions:

(1) A minimum of \$1,200,000 of this requirement must be in cash;

(2) The Contractor may include 100% of the book value (the depreciated value according to generally accepted accounting principles (GAAP)) of tangible health care delivery assets carried on its balance sheet;

(3) The GAAP value of intangible assets up to 10% of the minimum net worth required may be allowed.

2. Working Capital Requirements

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

a. If a Contractor's working capital falls below zero, the Contractor must immediately notify EOHHS and submit for EOHHS approval a written plan within 30 days of findings, addressing the action steps being taken to reestablish a positive working capital balance.

b. EOHHS may take any action it deems appropriate, including termination of the Contract, if the Contractor:

- (1) Fails to report a negative working capital balance that is subsequently identified through an audit;
 - (2) Does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time as determined by EOHHS;
 - (3) Violates a corrective plan approved by EOHHS or
 - (4) EOHHS determines that negative working capital cannot be corrected within a reasonable amount of time as determined by EOHHS.
- c. Notwithstanding the foregoing, CMS may take any action it deems appropriate, at any time, in order to protect beneficiary access to needed medical care.

B. Financial Stability

1. Financial Stability Plan

a. Throughout the term of this Contract, the Contractor must:

- (1) Remain financially stable;
- (2) Maintain adequate protection against insolvency in an amount determined by EOHHS, as follows:

(A) Provide to Enrollees all Covered Services required by this Contract for a period of at least 45 calendar days following the

date of insolvency or until written approval to cease providing such services is received from EOHHS whichever comes sooner;

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

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

(3) Immediately notify CMS and EOHHS when the Contractor has reason to consider insolvency or otherwise has reason to believe it or any subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the Contractor's board of the potential for insolvency; and

(4) Maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance; and annually demonstrate required liability protection to EOHHS.

(A) Insolvency Reserve

i. The Insolvency Reserve shall be defined as the funding resources available to meet costs of providing services to Enrollees for a period of 45 days in the event that the Contractor is determined insolvent. Funding the Insolvency Reserve shall be the sole responsibility of the Contractor,

regardless of any risk sharing arrangements with EOHHS or CMS.

- ii. EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within 45 days of the start of the Contract Year.
- iii. The Insolvency Reserve calculation shall be an amount equal to 45 days of the Contractor's estimated medical expenses, not to exceed 88% of the calculated value of 45 days of capitation payment revenue.
- iv. Within 30 calendar days of receipt of the Insolvency Reserve calculation, the Contractor must submit to EOHHS written documentation of its ability to satisfy EOHHS' Insolvency Reserve Requirement. The documentation must be signed and certified by the Contractor's chief financial officer.
- v. Subject to EOHHS' approval, the Contractor may satisfy the Insolvency Reserve Requirement through any combination of the following: restricted cash reserves; performance guarantee as specified in **Section 2.15.B.2**; insolvency insurance or reinsurance, performance bonds; irrevocable letter of credit; and other letters of credit or admitted assets as specified in **Appendix M**.

(5) Annually submit to EOHHS a report on outstanding litigation.

2. Performance Guarantees and Additional Security

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

- a. A promissory note from the Contractor's parent(s) or a performance bond from an independent agent in the amount of \$1,500,000 to guarantee performance of the Contractor's obligation to

provide Covered Services in the event of the Contractor's impending or actual insolvency; and

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

C. Other Financial Requirements

1. Auditing and Financial Changes

The Contractor must:

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

(1) Within 120 days after the end of the Contractor's fiscal year, provide CMS and EOHHS with the Contractor's annual audited financial statements prepared in accordance with the American Institute of Certified Public Accountants (AICPA) standards; and

(2) Demonstrate to the independent auditors that its internal controls are effective and operational as part of the annual audit engagement and provide CMS and EOHHS an independent auditor's report on the processing of the transactions using the American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements (SSAE) No. 16 and Chapter 647 of the Acts of 1989 (also known as the Internal Control Law). To comply with this requirement the Contractor must submit a service organization controls type 1 (SOC-1) report annually, within 30 days of when the independent auditor issues such report.

- b. Report annually or more frequently when requested by EOHHS, on any significant deficiencies in internal controls as follows:
- (1) Furnish EOHHS with a written report prepared by the independent auditor that performed the ICO's independent financial audit, describing significant deficiencies in the ICO's internal control structure noted by the accountant during the audit. No report need be issued if the accountant does not identify significant deficiencies.
 - (2) Describe in writing the remedial actions it has taken or proposes to take to correct significant deficiencies, if such actions are not described in the accountant's report. EOHHS may require the ICO to take additional or different corrective action to correct such deficiencies.
- c. Submit on an annual basis after each annual audit a representation letter signed by the Contractor's chief financial officer certifying that its organization is in sound financial condition and that all issues have been fully disclosed;
- d. Utilize a methodology approved by CMS and EOHHS to estimate incurred but not reported (IBNR) claims adjustments;
- e. Immediately notify CMS and EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency;
- f. Notify CMS and EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract;
- g. Advise CMS and EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new contracts, or business ventures being contemplated by the Contractor that may

negatively impact the Contractor's ability to perform under this Contract; and

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

2. Risk Arrangements

The Contractor may maintain provider risk arrangements. The Contractor must disclose these arrangements to CMS and EOHHS as follows and meet the additional requirements specified below. Except as they determine required by law, EOHHS and CMS shall not disclose the Contractor's provider contracts. Notwithstanding the foregoing nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i).

a. The Contractor must provide a description of any changes in its risk arrangements with all members of its Provider Network, including but not limited to primary care, specialists, hospitals, nursing facilities, other long term care providers, Behavioral Health Providers, and ancillary services. The Contractor shall make this description available to its Enrollees, or any prospective Enrollees upon request.

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

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

3. Other Information

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

4. Reporting

To demonstrate that the Contractor has met the requirements of this **Section 2.15**, the Contractor must submit to CMS and EOHHS all required financial reports, as described in this **Section 2.15** and **Appendix N**, in accordance with specified timetables, definitions, formats, assumptions, and certifications as well as any ad hoc financial reports required by CMS and EOHHS.

In the event that the Contractor is a non-federally qualified managed care organization (as defined in Section 1310(d) of the Public Health Service Act, it must report a description of certain transactions with parties of interest, as identified in Section 1903(m)(4)(A) of the Social Security Act.

5. Financial Responsibility for Post-stabilization Services

The Contractor must pay for Post-stabilization Services in accordance with 42 C.F.R. 438.114e.

6. Critical Access Hospitals

To the extent necessary to comply with the Commonwealth's statutory requirements set forth in Section 253 of Chapter 224 of the Acts of 2012, the Contractor shall ensure its payments to any licensed hospital facility operating in the Commonwealth that has been designated as a critical access hospital under 42 U.S.C. 1395i-4 are an amount equal to at least 101 percent of allowable costs under the Contractor's plan, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services.

7. Primary Care Payment Rates

As directed by EOHHS, including through bulletins or other written statements of policy, the Contractor shall set payment rates for primary care services provided by eligible Providers in accordance with Section 1202 of the ACA and 42 U.S.C. 1396a(13)(C), EOHHS policies, and all applicable federal and state laws, regulations, rules, and policies related to the implementation of such requirement. In the manner and frequency directed by EOHHS, the Contractor shall submit reports relating to this **Section 2.15.C.9** to EOHHS. Except as they determine required by law, EOHHS and CMS shall not disclose the Contractor's Provider Contracts. Notwithstanding the generality of the foregoing, the Contractor shall, in accordance with 42 C.F.R. 438.6(c)(5)(vi), for payments for primary care services in calendar years 2013 and 2014 furnished to Enrollees under 42 C.F.R. Part 447, subpart G:

- a. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 C.F.R. Part 447, subpart G; and
- b. Provide documentation to EOHHS, sufficient to enable EOHHS and CMS to ensure that provider payments increase as required by subpart (a) above.

2.16 Data Submissions, Reporting Requirements, and Surveys

A. General Requirements for Data

The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

1. All information CMS and EOHHS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2. Any information CMS and EOHHS require to comply with all applicable federal or State laws and regulations; and
3. Any information CMS or EOHHS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and enrollment/ disenrollment rates.

B. General Reporting Requirements

The Contractor shall:

1. Submit to EOHHS all applicable MassHealth reporting requirements in compliance with 42 C.F.R. § 438.602-606;
2. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. § 422.516, 42 C.F.R. § 423.514 and 42 C.F.R. § 438 et. seq.;
3. Submit to EOHHS all applicable MMP reporting requirements;
4. Submit to CMS and EOHHS all required reports and data in accordance with the specifications, templates and time frames described in this Contract;
5. In accordance with the timelines, definitions, formats and instructions contained herein or as specified by EOHHS, provide the following information. Where practicable, EOHHS shall consult with the Contractor to establish time frames and formats and detailed specifications reasonably acceptable to both parties;
 - a. Provide all information required under this Contract, including but not limited to, the requirements of this section, **Appendix D**, or other

information related to the performance of its or its first-tier, downstream, or related entities' responsibilities hereunder or under the subcontracts as reasonably requested by CMS or EOHHS;

- b. Provide any information in its or its First Tier, Downstream or Related Entities' possession sufficient to permit EOHHS to comply with 42 C.F.R. § 438; and
 - c. Provide any data from its or its first-tier, downstream or related entities' clinical systems, authorization systems, claims systems, medical record reviews, Network Management visits, and Enrollee and family input.
6. Upon request, participate in work groups led by EOHHS to develop reporting specifications and to adopt the reporting models formulated by these work groups and approved by EOHHS, pursuant to the timeline established by EOHHS;
 7. Upon request, provide EOHHS with the original data sets used by the Contractor in the development of any required reporting or ad-hoc reporting in accordance with the time frames and formats established by EOHHS;
 8. Upon request, submit to CMS and EOHHS any internal reports that the Contractor uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/ loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance;
 9. Report HEDIS, HOS, and CAHPS data, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by EOHHS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and EOHHS;
 10. Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS;

11. The Contractor shall, at the direction of EOHHS, require its PCPs who are not MassHealth Primary Care Clinicians (PCCs) to complete a practice infrastructure survey provided by EOHHS; and
12. Provide to CMS and EOHHS, in a form and format approved by CMS and EOHHS and in accordance with the timeframes established by CMS and EOHHS, all reports, data or other information CMS and EOHHS determine are necessary for compliance with the provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance.

C. Information Management and Information Systems

1. General

The Contractor shall:

- a. Maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract. The Contractor's Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following EOHHS standards:
 - (1) The EOHHS Unified Process Methodology User Guide;
 - (2) The User Experience and Style Guide Version 2.0;
 - (3) Information Technology Architecture Version 2.0; and
 - (4) Enterprise Web Accessibility Standards 2.0.
- b. Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS;
- c. For the purposes of quality management and Rating Category determination, accept, process, and report to CMS and the EOHHS uniform person-level Enrollee data, based upon a Comprehensive

Assessment process that includes ICD-9 (or, as applicable ICD-10) diagnosis codes, the Minimum Data Set (MDS-HC or MDS 2.0 or 3.0), and any other data elements deemed necessary by CMS and the EOHHS;

- d. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal;
 - e. Cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS; and
 - f. Actively participate in any EOHHS Systems Workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS.
2. Design Requirements

- a. The Contractor shall comply with EOHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.
- b. The Contractor's Systems shall interface with EOHHS's Legacy MMIS system, EOHHS's MMIS system, the EOHHS Virtual Gateway, and other EOHHS IT architecture.
- c. The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files, which include, but are not limited to:

(1) Inbound Interfaces

- (A) Daily Inbound Demographic Change File;
- (B) HIPAA 834 History Request File;
- (C) Inbound Co-pay Data File (daily); and
- (D) Monthly ICO Provider Directory.

(2) Outbound Interfaces

- (A) HIPAA 834 Outbound Daily File;

- (B) HIPAA 834 Outbound Full File;
 - (C) HIPAA 834 History Response;
 - (D) Fee-For-Service Wrap Services;
 - (E) HIPAA 820; and
 - (F) TPL Carrier Codes File.
- d. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.
 - e. The Contractor shall demonstrate controls to maintain information integrity.
 - f. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS.
3. System Access Management and Information Accessibility Requirements
- a. The Contractor shall make all Systems and system information available to authorized CMS, EOHHS and other agency staff as determined by CMS or EOHHS to evaluate the quality and effectiveness of the Contractor's data and Systems.
 - b. The Contractor is prohibited from sharing or publishing CMS or EOHHS data and information without prior written consent from CMS or EOHHS.
4. System Availability and Performance Requirements
- a. The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers 24 hours a day, seven days a week.
 - b. The Contractor shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to EOHHS upon request. In the event of System failure

or unavailability, the Contractor shall notify EOHHS upon discovery and implement the COOP immediately.

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

5. Virtual Gateway

If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, the Contractor shall:

- a. Submit all specified information including, but not limited to, MDS-HC assessment data, invoices, Contract or other information to EOHHS through these web-based applications;
- b. Comply with all applicable EOHHS policies and procedures related to such services;
- c. Use all business services through the Virtual Gateway as required by EOHHS;
- d. Take necessary steps to ensure that it, and its subcontractors or affiliates, has access to and utilize all required web-based services; and
- e. Execute and submit all required agreements, including subcontracts, Memoranda of Agreements, confidentiality and/or end user agreements in connection with obtaining necessary end user accounts for any Virtual Gateway business service.
- f. With Enrollee consent, assist Enrollees in providing EOHHS with their current address (residential and mailing), phone numbers and other demographic information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page Application on the Virtual Gateway, as follows:
 - (1) If the Contractor learns from an Enrollee or an authorized representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the Contractor obtains demographic information from the Enrollee or authorized representative, the Contractor shall provide such information to EOHHS by entering it into the Change Form via the My Account Page Application on the Virtual Gateway, after obtaining the

Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

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

2.17 Encounter Reporting

A. General

The Contractor must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations including the EOHHS Encounter Data Set Request, as may be updated from time to time. Furthermore, the Contractor's Systems shall generate and transmit Encounter Data files according to additional specifications as may be provided by CMS or EOHHS and updated from time to time. The Contractor shall maintain processes to ensure the validity, accuracy and completeness of the Encounter Data in accordance with the standards specified in this section. CMS and EOHHS

will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

B. Requirements

The Contractor shall:

1. Collect and maintain 100% Encounter Data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data;
2. Participate in site visits and other reviews and assessments by CMS and EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;
3. Upon request by CMS, EOHHS, or their designee, provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;
4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, EOHHS, or their designee, in consultation with the Contractor. Such Encounter Data shall include elements and level of detail determined necessary by CMS and EOHHS. As directed by CMS and EOHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC);
5. Provide Encounter Data to CMS and EOHHS on a monthly basis or within time frames specified by CMS and EOHHS in consultation with the Contractor, including at a frequency determined necessary by CMS and EOHHS to comply with any and all applicable statutes, rules, regulations and guidance;
6. Submit Encounter Data that is at a minimum 99% complete and 95% accurate. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the Contractor must have systems in place to monitor and audit claims. The Contractor must also correct and resubmit denied encounters as necessary. The data shall be considered complete and accurate if the error rate in the initial submission is no more than 3% and the number of encounters that need to be manually overridden is no more than 1%;

7. If CMS, EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not 99% complete and 95% accurate, the Contractor shall:
 - a. Notify CMS and EOHHS, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;
 - b. Submit for CMS and EOHHS approval, within a time frame established by CMS and EOHHS, which shall in no event exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;
 - c. Implement the CMS and EOHHS-approved corrective action plan within a time frame approved by CMS and EOHHS, which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to CMS and EOHHS for approval; and
 - d. Participate in a validation study to be performed by CMS, EOHHS, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is 99% complete and 95% accurate. The Contractor may be financially liable for such validation study.
8. Report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid.

Section 3. CMS and EOHHS Responsibilities

3.1 Contract Management

A. Administration

CMS and EOHHS will:

1. Designate a Contract Management Team that will include at least one representative from CMS and at least one contract manager from EOHHS authorized and empowered to represent CMS and EOHHS about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representative and the EOHHS representatives will act as liaisons between the Contractor and CMS and EOHHS for the duration of the Contract. The Contract Management Team will:
 - a. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.
 - b. Coordinate periodic audits and surveys of the Contractor;
 - c. Receive and respond to Complaints;
 - d. Conduct regular meetings with the Contractor;
 - e. Coordinate requests for assistance from the Contractor and assign CMS and EOHHS staff with appropriate expertise to provide technical assistance to the Contractor;
 - f. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or EOHHS; and
 - g. Inform the Contractor of any discretionary action by CMS or EOHHS under the provisions of the Contract;
 - h. Coordinate review of marketing materials and procedures; and
 - i. Coordinate review of Grievance and Appeals data, procedures.
2. Review, approve, and monitor the Contractor's Outreach and orientation materials and procedures;

- a. Review, approve, and monitor the Contractor's Complaint and Appeals procedures;
3. Monitor compliance with all applicable rules and requirements, and issue compliance notices, as appropriate;
4. Apply one or more of the sanctions provided in **Section 5.3.(N)**, including termination of the Contract in accordance with **Section 5.5**, if CMS and EOHHS determine that the Contractor is in violation of any of the terms of the Contract stated herein;
5. Conduct site visits as determined necessary by CMS and EOHHS to verify the accuracy of reported data; and
6. Coordinate the Contractor's external quality reviews conducted by the external quality review organization.

B. Performance Evaluation

CMS and EOHHS will, at their discretion:

1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in **Sections 2.16 and 2.17**, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and the Commonwealth will provide the Contractor with the written results of these evaluations;
2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and
4. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

3.2 Enrollment and Disenrollment Systems

A. General

CMS and EOHHS will maintain systems to provide:

1. Enrollment, disenrollment, rating-category determination information to the Contractor; and
2. Continuous verification of eligibility status.

B. EOHHS Customer Service Enrollment Vendor

EOHHS or its designee shall assign a staff person(s) who shall have responsibility to:

1. Develop generic materials to assist Eligible Members in choosing whether to enroll in the Demonstration. Said materials shall present the Contractor's ICO in an unbiased manner to Members eligible to enroll in the Contractor's ICO. EOHHS may collaborate with the Contractor in developing ICO-specific materials;
2. Present the Contractor's ICO in an unbiased manner to Eligible Members or those seeking to transfer from one ICO to another. Such presentation(s) shall ensure that Members are informed prior to enrollment of the following:

- a. The rights and responsibilities of participation in the Demonstration;
 - b. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the Comprehensive Assessment, and the ICT; and
 - c. Orientation and other Member services made available by the Contractor;
3. Enroll, disenroll and process transfer requests of Enrollees in the Contractor's ICO, including completion of EOHHS's enrollment and disenrollment forms;
 4. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;
 5. Be knowledgeable about the Contractor's policies, services, and procedures; and
 6. At its discretion, develop and implement processes and standards to measure and improve the performance of the EOHHS customer service enrollment vendor staff. EOHHS shall monitor the performance of the EOHHS customer service enrollment vendor.

C. Supplemental Enrollment Information

At the direction of EOHHS and CMS, the Contractor shall process supplemental transactions with CMS' enrollment vendor to provide supplemental enrollment information, such as Part D ID numbers, on a schedule to be provided by EOHHS and CMS.

Section 4: Payment and Financial Provisions

4.1 General Financial Provisions

A. Capitation Payments

CMS and EOHHS will each contribute to the total capitation payment. CMS and EOHHS will each make monthly payments to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three monthly payments for each Enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from EOHHS reflecting coverage of Medicaid services (MassHealth Component).

The Medicare Parts A/B Component will be risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in **Section 4.2.D.1.a**. The Part D direct subsidy portion of the Medicare Part D Component will be risk adjusted using the Part D RxHCC Model. MassHealth will assign each Enrollee to a Rating Category (RC) according to the individual Enrollee's clinical and demographic status and setting of care for the purpose of risk adjusting the MassHealth Component.

CMS and EOHHS will provide the Contractor with a rate report on an annual basis for the upcoming calendar year.

B. Demonstration Year Dates

Capitation Rate updates will take place on January 1st of each calendar year. However, savings percentages and quality withhold percentages (see **Sections 4.2.C.1** and **4.3.D**) will be applied based on Demonstration Years, as follows:

Demonstration Year	Calendar Dates
1	First Effective Enrollment Date - December 31, 2014
2	January 1, 2015 - December 31, 2015
3	January 1, 2016 - December 31, 2016

C. Sharing of Contractor-level Payment Information

On a regular basis, CMS will provide EOHHS with the Contractor-level payment information in the Medicare Plan Payment Report. The use of such information by EOHHS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, EOHHS will also provide to CMS Contractor-level payment information including the Medicaid Capitation Payments.

4.2 Capitated Rate Structure

A. Underlying Rate Structure for the MassHealth Component

EOHHS will pay the Contractor a monthly capitation (the MassHealth Component) for Enrollees according to the Rating Categories (RCs) as follows. Notwithstanding the provision below requiring submission of an MDS-HC, EOHHS may make temporary RC assignments using other available data sources pending the Contractor’s timely submission of a completed MDS-HC. EOHHS and CMS may propose modifications, additions, or deletions to the Rating Categories over the course of the Demonstration. Any modifications, or additions, or deletions to the Rating Categories will be subject to agreement by the other governmental party, EOHHS and CMS will inform the Contractor of such changes to the Rating Categories in writing, and the Contractor shall accept such changes.

1. Facility-based Care (F1)

Enrollees will be classified as Facility-based Care if they have been identified by MassHealth as having a stay exceeding 90 days in a skilled nursing facility or nursing facility or a chronic hospital, rehabilitation hospital, or a psychiatric hospital.

2. Community Tier 3 – High Community Need (C3)

Enrollees will be classified as High Community Needs as follows:

a. Enrollees will be classified as High Community Needs if they do not meet F1 criteria and their most recent MDS-HC assessment indicates they:

(1) Have a daily skilled need, or daily chronic and stable routine need, for any qualifying treatments or programs, for which the Enrollee requires assistance;

(2) Have a skilled need, or a chronic and stable routine need, for which the Enrollee requires assistance, at least 3 days per week for any qualifying treatment or program along with 2 or more ADL impairments requiring more than supervision;

(3) Have 4 or more ADL impairments requiring more than supervision;

(4) Have 4 or more ADL impairments (including those requiring only supervision), and have moderately to severely impaired cognitive decision making skills; or

(5) Have 4 or more ADL impairments (including those requiring only supervision), and have one or more of the behavioral health

diagnoses listed in **Section 4.2.A.3.a** below, confirmed in medical records, that are chronic and ongoing.

- b. All activities will contribute to the ADL impairment count, but limitations dressing upper body and limitations dressing lower body together will be treated as a single ADL. Supervision needs will contribute to the ADL impairment count only if there is a corresponding cognitive deficit or select behavioral health diagnosis also present, and if there are 4 or more ADL impairments.
- c. After CY2013, Enrollees meeting the above criteria for this rating tier will be further stratified based on the indication of specific diagnoses as follows:

(1) Community Tier 3 – Very High Community Need (C3B)

Enrollee meets the criteria of Section 4.2.A.2.a, and their most recent MDS-HC assessment indicates one or more of the diagnoses listed below, reflecting quadriplegia, ALS, Muscular Dystrophy or respirator dependence:

a. From October 1, 2013 – September 30, 2015 using ICD-9:

- i. 344.0x and 343.2x
- ii. 335.20
- iii. 359.0x and 359.1x
- iv. V461x

b. Beginning on October 1, 2015, using ICD-10:

- i. G80.0
- ii. G82.50
- iii. G82.51
- iv. G82.52
- v. G82.53

- vi. G82.54
- vii. G71.0
- viii. G71.2
- ix. G12.21
- x. Z99.11
- xi. Z99.12

(2) Community Tier 3 – High Community Need (C3A)

Enrollee meets the criteria of **Section 4.2.A.2.a**, but does not have one of the diagnoses specified in **Section 4.2.A.2.c (1)**.

3. Community Tier 2 - Community High Behavioral Health (C2)

- a. Enrollees will be classified as Community High Behavioral Health if they do not meet F1 or C3 criteria, and their most recent MDS-HC assessment indicates one or more of the behavioral health diagnoses listed below, reflecting an ongoing condition such as schizophrenia or episodic mood disorder; psychosis; or alcohol or drug dependence not in remission. Diagnoses must be confirmed in medical records, and be chronic and ongoing.

(1) From October 1, 2013 – September 30, 2015 using ICD-9:

- a. 295.xx
- b. 296.xx
- c. 298.9x
- d. 303.90, 303.91, 303.92
- e. 304.xx, excluding 304.x3

(2) Beginning on October 1, 2015, using ICD-10:

- a. F10.2-F10.29, excluding F10.21
 - b. F11.2-F11.29, excluding F11.21
 - c. F12.2-F12.29, excluding F12.21
 - d. F13.2-F13.29, excluding F13.21
 - e. F14.2-F14.29, excluding F14.21
 - f. F15.2-F15.29, excluding F15.21
 - g. F16.2-F16.29, excluding F16.21
 - h. F18.2-F18.29, excluding F18.21
 - i. F19.2-F19.29, excluding F19.21
 - j. F20-F20.9, F25-F25.9 (schizophrenia)
 - k. F28, F9 (other psychosis)
 - l. F30-F30.9 (bi polar)
 - m. F31-F31.9 (bi polar)
 - n. F32-F32.9 (major depression)
 - o. F33-F33.9 (major depression)
 - p. F34.8, F34.9, F39 (mood disorders)
- f. After CY2013, Enrollees meeting the above criteria for this rating tier will be further stratified based on criteria, to be developed by EOHHS and CMS, which are indicative of higher than average costs for this rating tier. The Rating Category assignment will be as follows:
- (1) Community Tier 2 - Community Very High Behavioral Health (C2B).

Enrollee meets the criteria of **Section 4.2.A.3.a**, and their most recent MDS-HC assessment and/or other information sources reflect one or more specific diagnoses or other characteristics indicative of higher than average costs for this rating tier.

(2) Community Tier 2 – Community High Behavioral Health (C2A)

Enrollee meets the criteria of **Section 4.2.A.3.a**, but does not have one of the diagnoses or characteristics specified in **Section 4.2.A.3.b (1)**.

4. Community Tier 1 – Community Other (C1)

Enrollees will be classified as Community Other, if they do not meet F1, C2, or C3 criteria.

B. Underlying Rate Structure for Medicare Components of the Capitation Rate

1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in **Section 4.2.D.1.a**. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

2. Medicare A/B Component

The Medicare baseline spending for Parts A/B services are a blend of the Medicare Fee For Service (FFS) standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population projected to otherwise be in each program in the absence of the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment was fully applied to the FFS county rates in 2013 and 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS

county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, for CY 2015 and future years the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county (for CY 2013 and CY 2014 the baseline was the 3-star county rate).

- a. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as per member per month (PMPM) standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.
- b. The Medicare A/B Component will be updated annually consistent with annual Fee-for-Service (FFS) estimates and Medicare Advantage rates released each year with the annual rate announcement.
- c. If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the ICO, but will obtain the hospice service through the Medicare FFS benefit and the ICO would no longer receive the Medicare Parts A/B Component for that Enrollee as described in this section. Medicare hospice services and hospice drugs and all other Original Medicare services would be paid for under Medicare FFS. ICOs and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. ICOs would continue to receive the Medicare Part D Component for all non-hospice covered drugs. Election of hospice services does not change the MassHealth Component.

3. Medicare Part D

- a. The Medicare Part D Component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average

monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

- b. The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts.

C. **Aggregate Savings Percentages**

1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the MassHealth Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with **Section 4.3.C.3**.
 - a. Demonstration Year 1, as divided into the following two time periods:
 - (1) First six months following the first Effective Enrollment Date: 0%
 - (2) After the first six months following the first Effective Enrollment Date through December 31, 2014: 1%
 - b. Demonstration Year 2: 0%
 - c. Demonstration Year 3: 0%
2. Except as otherwise specified, including in Section 4.3.C.2, rate updates will take place on January 1st of each calendar year.
3. Savings percentages will not be applied to the Part D Component. CMS will monitor Part D costs on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4. EOHHS may submit for CMS approval a methodology whereby the savings percentages applied to the MassHealth Component may vary by RC, but will in the aggregate reflect the savings percentages specified in **Section 4.2.C.1**. If implemented, this methodology will take effect no sooner than calendar year 2015.

D. Risk Adjustment Methodology

1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified in **Section 4.2.D.1.a**, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

a. Coding Intensity Adjustment Factor

- (1) CMS will calculate calendar year 2013 rates as if the coding intensity adjustment factor were not applied, to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B baseline for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.
- (2) In calendar year 2014, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in **Section 4.2.D.1.a(5)**. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in 2014 with Medicare Advantage experience in 2013, prior to the Demonstration.
- (3) In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in **Section 4.2.D.1.a(5)**. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014.

- (4) After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Enrollees, except as indicated in **Section 4.2.D.1.a(5)**.
 - (5) The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.
2. Medicare Part D: The Medicare Part D national average bid amount will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.
3. Medicaid: For the MassHealth Component of the capitated rate, EOHHS will rely on Rating Categories described in **Section 4.2.A** and in Demonstration Years 2 and 3 may use High-Cost Risk Pools (HCRPs) for certain RCs, described in **Section 4.2.E**, to account for differences in risk among the eligible population.

E. High-Cost Risk Pools

1. In Demonstration Years 2 and 3, EOHHS may establish High-Cost Risk Pools (HCRPs) to account for enrollment of high-cost beneficiaries, defined based on spending for select MassHealth Long-Term Services and Supports and services above a defined threshold within MassHealth RCs across ICOs. For each RC with an HCRP, a portion of the base MassHealth Component will be withheld from all ICOs into a risk pool. The risk pool will be divided across ICOs based on their percent of the total costs above the per Enrollee threshold amount associated with the high-cost beneficiaries. Any sums withheld for a High Cost Risk Pool during Demonstration Years 1 and 2 will be refunded to the Contractor by approximately June 30, 2015.
2. Applicable MassHealth RCs:

- a. Facility-based Care (F1)
 - b. Community Tier 3 - High Community Need (C3)
3. HCRPs will be utilized until additional long-term care risk adjustment methodology is in place.
4. Details
- a. The lesser of 1) the total amount withheld into the pool, and 2) the total costs that are above the per Enrollee threshold will be distributed among ICOs in proportion to the amount of total costs above the per Enrollee threshold that are attributed to each ICO for their high cost Enrollees.
 - b. Any amounts remaining in the pool (in the case where the pool exceeds total costs over the per Enrollee threshold) will be distributed among ICOs in proportion to their contribution to the pool.
5. The per Enrollee threshold and the withhold amounts will be established annually. For CY 2013, thresholds will be established on an average PMPM basis due to the enrollment phase-in that will occur during the initial months of the Demonstration. Thresholds for subsequent years will be based on annual expenses.
- a. HCRP reconciliation will occur annually based on 9 months of claims run-out after the end of each calendar year
 - b. Applicable costs:

- (1) Cost must be for Covered Services incurred while Enrollee is in the Rating Category applicable to the pool.

- (2) Applicable costs include Personal Assistance Services (including administrative costs paid to Fiscal Intermediaries for Self-directed PCA), Personal Care Management Services, Day Habilitation services, Adult Day Health, Adult Foster Care, Group Adult Foster Care, Diversionary Behavioral Health Services, new Community-based Services, IL-LTSS coordination activities, Dental care, and facility care beyond skilled care days that would be covered by Medicare in FFS. Applicable costs must be net of Enrollee contributions to care.

- (3) IL-LTSS coordinator expenses will be priced based on utilization using a standardized unit cost determined by EOHHS.

- (4) The Contractor must submit all claims for Enrollees with total costs exceeding the per Enrollee threshold within 300 days following the end of the calendar year.

- (5) The EOHHS and the Contractor agree that to the extent there are differences between expenditures as reflected in the encounter, cost, financial reporting or other data submitted by the Contractor, the EOHHS and the Contractor will confer and make a good faith effort to reconcile those differences before the reconciliation of the HCRPs.
 - (A) The review procedures may include an audit, to be performed by the EOHHS, or its authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. EOHHS and CMS reserve the right to adjust expenditures for services that are reimbursed at more than 5% above the average

reimbursement rate of all ICOs. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or EOHHS for failure to adjust expenditures for services of any ICO.

4.3 Payment Terms

CMS and EOHHS will each make monthly, prospective capitation payments to the Contractor. The EOHHS will categorize Enrollees by RC according to the process outlined in **Section 4.2.A**. The MassHealth Component for each RC will be the product of the number of Enrollees in each category multiplied by the payment rate for that RC. The Medicare Parts A/B Component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D National Average Monthly Bid Amount, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts. Enrollee contribution to care amounts will be deducted from the MassHealth Component of the monthly capitation payment amount, in accordance with **Section 4.3(B)**.

A. Timing of Capitation Payments

1. Enrollments

CMS and EOHHS will make monthly per member per month capitation payments to the Contractor. The PMPM capitation payment for a particular month will reflect payment for the beneficiaries with effective enrollment into the Contractor's ICO as of the first day of that month, as described in **Section 2.3.A**.

2. Disenrollments

The final per member per month capitation payment made by CMS and EOHHS to the Contractor for each Enrollee will be for the month in which the disenrollment was submitted, the Enrollee loses eligibility, or the Enrollee dies (see **Section 2.3.B**).

B. Enrollee Contribution to Care Amounts

If, in the financial eligibility process conducted by EOHHS, an Enrollee residing in a nursing facility is determined to owe a monthly Enrollee-paid amount, such amounts are the Enrollee's contribution to care. At the time of enrollment, and as adjusted thereafter, EOHHS will advise the Contractor of the amount of the Enrollee's contribution to care. When an Enrollee contribution to care is established, MassHealth will subtract that amount from the monthly capitation payment for that Enrollee. The Contractor is responsible for collecting this amount from the Enrollee subject to the Enrollee rights provisions of the Contractor's Evidence of Coverage (see **Appendix C**).

C. Modifications to Capitation Rates

CMS and EOHHS will jointly notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in **Section 4.7**.

1. Rates will be updated using a similar process for each calendar year. Subject to **Section 4.3.C.2**, changes to the Medicare and MassHealth baselines outside of the annual Medicare Advantage and Part D rate announcements will be made only if and when CMS and EOHHS jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in enrollment assumptions; major changes or discrepancies in Federal law and/or State policy compared to assumptions about Federal law and/or state law or policy used in the development of baseline estimates; and changes in coding intensity.

2. Modifications to Rate Year 2015 MassHealth rates that are published after October 1, 2015 only apply if the Contractor participates in the Demonstration through December 31, 2016.
3. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.
4. Subject to **Section 4.3.C.2**, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and EOHHS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.
5. Changes to the savings percentages will be made if and when CMS and EOHHS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

D. Quality Withhold Policy for MassHealth and Medicare A/B Components of the Risk-Adjusted Rate

1. Under the Demonstration, both CMS and EOHHS will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D Component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.
2. CMS and EOHHS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

3. Whether or not the Contractor has met the quality withhold requirements in a given year will be made public.

4. Additional details regarding the quality withholds, including the more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

5. Withhold Measures in Demonstration Year 1
 - a. **Figure 4.1** below identifies core withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for a 1% withhold. Additional details, including technical specifications, withhold methodology and required benchmarks, will be provided in subsequent guidance.

 - b. Because Demonstration Year 1 crosses calendar and Contract years, the Contractor will be evaluated to determine whether it has met required quality withhold requirements at the end of both CY 2013 and CY 2014. The determination in CY 2013 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2013. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 4.1: Quality Withhold Measures for Demonstration Year 1

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Encounter data (for CY 2014 only)	Submission of production Prescription Drug Event and Risk Adjustment System files.	CMS/State defined process measure	X	
Assessments	Percent of Enrollees with an in-person assessment for care planning purposes completed within 90 days of enrollment.	CMS/State defined process measure	X	

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Tracking of demographic information	Determination that the Contractor can demonstrate that the ICO Centralized Enrollee Record allows recording of specific demographic data including race, ethnicity, primary language, and homelessness, in compliance with contract requirements.	CMS/State defined process measure		X
Documentation of care goals (for CY 2014 only)	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Access to an IL-LTSS Coordinator (for CY 2014 only)	Percent of Enrollees with LTSS needs who have an IL-LTSS Coordinator.	CMS/State defined process measure		X
Consumer governance board	Establishment of Consumer advisory board or inclusion of Consumers on governance board consistent with contract requirements.	CMS/State defined process measure	X	

6. Withhold Measures in Demonstration Years 2 and 3

- a. The quality withhold will be 0% in Demonstration Year 2 and 1% in Demonstration Year 3.
- b. Payment will be based on performance on the quality withhold measures listed in **Figure 4.2**, below.

Figure 4.2: Quality Withhold Measures for Demonstration Years 2 and 3

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
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Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Getting Appointments and Care Quickly (for DY 2 only)	<p>Percent of the best possible score the plan earned on how quickly members get appointments and care:</p> <ul style="list-style-type: none"> In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? 	AHRQ/CAHPS	X	
Customer Service (for DY 2 only)	<p>Percent of best possible score the plan earned on how easy it is to get information and help when needed:</p> <ul style="list-style-type: none"> In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out? 	AHRQ/CAHPS	X	
Plan all-cause readmissions	<p>Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.</p>	NCQA/HEDIS	X	
Annual flu vaccine	<p>Percent of plan members who got a vaccine (flu shot) prior to flu season.</p>	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	<p>Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.</p>	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Withhold Measure	State-Specified Withhold Measure
Screening for clinical depression and follow-up care	Percentage of patients ages 18 years and older screened for clinical depression using an age-appropriate standardized tool AND follow-up plan documented.	CMS	X	
Controlling blood pressure	Percentage of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for diabetes medications	Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Initiation and engagement of alcohol and other drug dependence treatment	<p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:</p> <ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. 	NCQA/HEDIS		X
Encounter data (for DY 3 only)	Encounter data submitted accurately and completely in compliance with Contract requirements.	CMS/State defined process measure	X	

E. American Recovery and Reinvestment Act of 2009

All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

1. The Contractor shall offer Indian Enrollees the option to choose an Indian health care provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services;
2. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to Covered Services for Indian Enrollees;
3. The Contractor shall pay both network and non-network Indian Health Care Providers or I/T/U who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee-for-service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian Health Care Provider or I/T/U;
4. The Contractor shall make prompt payment to Indian Health Care Providers; and
5. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider.
6. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian health care provider; Indian Health Service; an I/T/U or through referral under contract health services.

F. Suspension of Payments

EOHHS may suspend payments to the Contractor in accordance with 42 C.F.R. §455.23 and 42 C.F.R. § 422.750, *et seq.* and 130 CMR 450, *et seq.* as determined necessary or appropriate by EOHHS. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

G. One-time 72 Hour Medication Supply

In accordance with 130 CMR 406.414(c), if a pharmacist cannot bill Contractor at the time an Enrollee presents the pharmacist with a prescription for a MassHealth covered medication and MassHealth pays for a one-time 72 hour supply of the prescribed medications, Contractor shall reimburse MassHealth for such sum, as set forth in **Section 2.9.A.1.e.**

H. Federally-Qualified Health Centers (FQHC)

Where the Contractor enters into a contract for the provision of services with a FQHC or a rural health clinic (RHC), the Contractor shall provide payment that is not less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC.

4.4 Transitions Between Rating Categories and Risk Score Changes

A. Rating Category Changes

The MassHealth Component of the Capitation Rates will be updated following a change in an Enrollee's status, based on facility status and the Minimum Data Set-Home Care (the MDS-HC), or any subsequent documentation required by CMS and the Commonwealth as follows.

On a monthly basis, as part of capitation payment processing, the Rating Category of each Enrollee will be determined based on the Enrollee's facility status and the most recent MDS-HC information as of the 1st of the month. With the exception of F1, Rating Categories will be determined based on assessment information provided to the MassHealth MDS-HC system by the Contractor's nurse reviewers. MDS-HC information will be updated within 90 days of enrollment as described in **Section 2.6.** and at least annually, including when substantial change in the Enrollee's status occurs.

B. Medicare Risk Score Changes

Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.5 Reconciliation

CMS and EOHHS will implement a process to reconcile enrollment and capitation payments for the Contractor that will take into consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or Enrollee contribution amounts; changes in CMS-HCC and RxHCC risk scores; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

A. MassHealth Capitation Reconciliation

MassHealth will:

1. Perform a quarterly reconciliation of the monthly capitation payments as described below:

- a. Calculate the correct MassHealth Component of the Capitation Rate for each month per Enrollee by determining the Enrollee's appropriate RC and the appropriate Enrollee contribution, as well as enrollment and eligibility status; and
 - b. Reconcile the monthly MassHealth component of the Capitation Rate paid per Enrollee for each month of the quarter with the correct Capitation Rate as calculated in **Section 4.5.A.1.a** above;
2. Remit to the Contractor the full amount of any underpayment it identifies pursuant to **Section 4.5.A.1**. The Contractor must remit to EOHHS the full amount of any overpayments identified by EOHHS pursuant to **Section 4.5.A.1**. Such payment shall be made either through a check or, at the discretion of EOHHS, through adjustment or recoupment of future capitation and/or reconciliation payments.
 3. Reconciliation for the MassHealth Component may also occur based on a longer and/or older prior period as appropriate and necessary.

B. Medicare Capitation Reconciliation

Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

C. Audits/Monitoring

CMS and EOHHS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and EOHHS.

D. Family Planning Services Reconciliation Process

EOHHS shall perform an annual family planning services reconciliation as follows. EOHHS shall:

1. Calculate all FFS claims paid by EOHHS for family planning services, including family planning pharmacy services, provided to Enrollees each CY; and
2. Deduct the amount of such claims paid from a future capitation payment to the Contractor after written notification to the Contractor of the amount and timing of such deduction.

E. Continuing Services Reconciliation

For each Contract Year, EOHHS shall perform a Continuing Services reconciliation as follows:

1. The Contractor shall process and pay its Providers' claims for all Continuing Services at the Contractor's contracted rate with its Providers.
2. EOHHS shall perform a reconciliation by June 30th, following the end of the CY to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by the BOH and which were provided following the conclusion of the final internal Appeal ("approved Continuing Service claims"); provided that the Contractor submits to EOHHS by March 31st, following the end of the CY, all data regarding such services as required in **Section 4.5.E.4**.
3. EOHHS shall pay the Contractor no later than 12 months following the end of the CY being reconciled, the total value of the approved Continuing Service claims referenced in **Section 4.5.E.2** that were provided within the applicable CY, provided the Contractor timely submitted all data required by EOHHS pursuant to this **Section 4.5.E**.

4. Approved Continuing Service claims shall include, at a minimum, the following information:
 - a. Enrollee information by MassHealth identification number, including Medicare identification number, date of birth, sex, dates of enrollment, the date on which the Continuing Services were provided, and current enrollment status;
 - b. Costs incurred, by MassHealth identification number, and Medicare identification number, including date of service;
 - c. Such other information as may be required pursuant to any EOHHS request for information;
 - d. The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Enrollee by the Contractor; and
 - e. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed by EOHHS. If an audit is not conducted, EOHHS shall reimburse the Contractor as otherwise provided in this **Section 4.5.E**.

4.6 Risk Corridors

Risk corridors will be established for Demonstration Years 1, 2, and 3.

A. General Provisions

1. Calculation of Gains and Losses

The risk-sharing arrangement described in this section of the Contract may result in payment by EOHHS and CMS to the Contractor or by the Contractor to EOHHS and CMS.

- a. All payments to be made by EOHHS and CMS to the Contractor or by the Contractor to EOHHS and CMS will be calculated and determined jointly by EOHHS and CMS.
- b. All calculations, determined jointly by EOHHS and CMS, will be based on the Contractor's reporting of Actual and Adjusted Service and Non-Service Expenditures, as required in **Section 4.6.B.4** below. All financial reporting will be subject to review and/or audit at EOHHS' and CMS' discretion.
- c. CMS and EOHHS will perform interim and final settlements of the payments made by the Contractor to CMS and EOHHS, or by CMS and EOHHS to the Contractor, as described in **Section 4.6.B.4** below.

2. Allowable Expenditures

- a. CMS and EOHHS shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on encounter data, cost data, and financial reporting data submitted by the Contractor (as required by **Section 4.6.B.4** below, and **Section 2.15-2.17** of this Contract). CMS and EOHHS reserve the right to audit Actual and Adjusted Service and Non-Service Expenditure data.

- b. CMS, EOHHS, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, EOHHS and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the interim and final settlements.

The review procedures may include a review of the Contractor's encounter data and/or audit, to be performed by the CMS and/or EOHHS, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive.

- c. EOHHS and CMS reserve the right to adjust expenditures for services that are reimbursed at more than 5% above the average reimbursement rate of all ICOs. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or EOHHS for a determination to adjust or a failure to adjust expenditures for services of any ICO.

B. Aggregate Risk Sharing Corridors

The Demonstration will utilize a tiered Contractor-level symmetrical risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after application of any HCRP or risk adjustment methodologies (e.g. CMS-HCC), and as if all Contractors had received the full quality withhold payment.

1. Risk Corridor Share

The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Adjusted

Capitation Rate Revenue. Losses and gains will be determined using the Risk Corridor Percentage.

2. Risk Corridor Percentage and Payment/Recoupment

a. Demonstration Year 1 - If the Contractor participates in the Demonstration at least through June 30, 2015, the following risk corridors apply for the experience during Demonstration Year 1:

- (1) For the portion of gains and/or losses of 0 through 1.0%, the Contractor bears 100% of the gain/loss. For the portion of gains and/or losses of 1.1% through 10.0%, the Contractor bears 10% of the gain/loss and EOHHS and CMS share in the other 90%, as described in **Section 4.6.B.1**. For the portion of gains and/or losses of 10.1% through 20.0%, the Contractor bears 50% of the gain/loss and EOHHS and CMS share in the other 50%, as described in **Section 4.6.B.1**. As further described in **Section 4.6.B.2.a.(2) and 4.6.B.2.a.(8)** below, for the portion of gains and/or losses of greater than 20.0%, the Contractor bears 100% of the gain/loss.
- (2) For Risk Corridor Percentages greater than 120.0%, EOHHS and CMS will make payment to the Contractor of 13.1% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is at full financial risk for amounts greater than 120.0%.
- (3) For Risk Corridor Percentages of 110.1% through 120.0%, EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 110.0%], plus the amount described in **Section 4.6.B.2.a(4)**, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.
- (4) For Risk Corridor Percentages of 101.1% through 110.0%, EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied

by 90% of [Risk Corridor Percentage minus 101.0%], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.

- (5) For Risk Corridor Percentages of 99.0% through 101.0%, no payment will be made by EOHHS and CMS to the Contractor, or by the Contractor to EOHHS and CMS.
- (6) For Risk Corridor Percentages of 90.0% through 98.9%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 90% of [Risk Corridor Percentage minus 89.9%], with the share of the payment made to EOHHS and CMS as described in **Section 4.6.B.1** above.
- (7) For Risk Corridor Percentages of 80.0% through 89.9%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 79.9%], plus the amount described in **Section 4.6.B.2.a(6)**, with the share of the payment made to EOHHS and CMS as described in **Section 4.6.B.1** above.
- (8) For Risk Corridor Percentages less than 80.0%, the Contractor will make payment to EOHHS and CMS of 13.1% of the Adjusted Capitation Rate Revenue, with the share of the payment made to EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is not obligated to make any additional payment for amounts below 80.0%.

b. Demonstration Year 2:

- (1) For the portion of gains and/or losses of 0 through 3.0%, the Contractor bears 100% of the gain/loss. For the portion of gains and/or losses of 3.1% through 10.0%, the Contractor bears 50% of the gain/loss and EOHHS and CMS share in the other 50%, as described in **Section 4.6.B.1**. For the portion of gains and/or losses of 10.1% and greater, the Contractor bears 100% of the gain/loss.

- (2) **For** Risk Corridor Percentages greater than 110.0%, EOHHS and CMS will make payment to the Contractor of 3.5% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is at full financial risk for amounts greater than 110.0%.
- (3) **For** Risk Corridor Percentages of 103.1 through 110.0%, EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 103.0%], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.
- (4) For Risk Corridor Percentages of 97.0% through 103.0%, no payment will be made by EOHHS and CMS to the Contractor, or by the Contractor to EOHHS and CMS.
- (5) **For** Risk Corridor Percentages of 96.9% through 90.0%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [97.0% minus the Risk Corridor Percentage], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.
- (6) **For** Risk Corridor Percentages less than 90.0%, the Contractor will make payment to CMS and EOHHS of 3.5% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is not obligated to make any additional payment for amounts below 90.0%.

c. Demonstration Year 3:

- (1) For the portion of gains and/or losses of 0 through 4.0%, the Contractor bears 100% of the gain/loss. For the portion of gains and/or losses of 4.1% through 8.0%, the Contractor bears 50% of the gain/loss and EOHHS and CMS share in the other 50%, as described in **Section 4.6.B.1**. For the portion of gains and/or losses of 8.1% and greater, the Contractor bears 100% of the gain/loss.

- (2) For Risk Corridor Percentages greater than 108.0%, EOHHS and CMS will make payment to the Contractor of 2.0% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is at full financial risk for amounts greater than 108.0%.
 - (3) For Risk Corridor Percentages of 104.1 through 108.0%, EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 104.0%], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.
 - (4) For Risk Corridor Percentages of 96.0% through 104.0%, no payment will be made by EOHHS and CMS to the Contractor, or by the Contractor to EOHHS and CMS.
 - (5) For Risk Corridor Percentages of 95.9% through 92.0%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [96.0% minus the Risk Corridor Percentage], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.
 - (6) For Risk Corridor Percentages less than 92.0%, the Contractor will make payment to CMS and EOHHS of 2.0% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is not obligated to make any additional payment for amounts below 92.0%.
- d. Demonstration Year 1 - If the Contractor does not participate in the Demonstration at least through June 30, 2015, the following risk corridors apply for the experience during DY1:
- (1) For the portion of gains and/or losses of 0 through 1.0%, the Contractor bears 100% of the gain/loss. For the portion of gains and/or losses of 1.1% through 3.0%, the Contractor bears 10% of the gain/loss and EOHHS and CMS share in

the other 90%, as described in **Section 4.6.B.1**. For the portion of gains and/or losses of 3.1% through 20.0%, the Contractor bears 50% of the gain/loss and EOHHS and CMS share in the other 50%, as described in **Section 4.6.B.1**. As further described in **Section 4.6.B.2.d.(2) and 4.6.B.2.d.(8)** below, for the portion of gains and/or losses of greater than 20.0%, the Contractor bears 100% of the gain/loss.

- (2) For Risk Corridor Percentages greater than 120.0%, EOHHS and CMS will make payment to the Contractor of 10.3% of the Adjusted Capitation Rate Revenue, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above. The Contractor is at full financial risk for amounts greater than 120.0%.

- (3) For Risk Corridor Percentages of 103.1% through 120.0% , EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 103.1%], plus the amount described in **Section 4.6.B.2.d(4)**, with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.

- (4) For Risk Corridor Percentages of 101.1% through 103.1%, EOHHS and CMS will make payment to the Contractor equaling the Adjusted Capitation Rate Revenue multiplied by 90% of [Risk Corridor Percentage minus 101.0%], with the share of the payment made by EOHHS and CMS as described in **Section 4.6.B.1** above.

- (5) For Risk Corridor Percentages of 99.0% through 101.0%, no payment will be made by EOHHS and CMS to the Contractor, or by the Contractor to EOHHS and CMS.

- (6) For Risk Corridor Percentages of 97.0% through 98.9%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 90% of [Risk Corridor Percentage minus 99.0%], with the share of the payment made to EOHHS and CMS as described in **Section 4.6.B.1** above.

(7) For Risk Corridor Percentages of 80.0% through 96.9%, the Contractor will make payment to EOHHS and CMS equaling the Adjusted Capitation Rate Revenue multiplied by 50% of [Risk Corridor Percentage minus 97.0%], plus the amount described in Section 4.6.B.2.d(6), with the share of the payment made to EOHHS and CMS as described in Section 4.6.B.1 above.

(8) For Risk Corridor Percentages less than 80.0%, the Contractor will make payment to EOHHS and CMS of 10.3% of the Adjusted Capitation Rate Revenue, with the share of the payment made to EOHHS and CMS as described in Section 4.6.B.1 above. The Contractor is not obligated to make any additional payment for amounts below 80.0%.

3. Risk Sharing Corridor Tables (for illustrative purposes only)

a. Demonstration Year 1, if the Contractor participates in the Demonstration at least through June 30, 2015:

Incremental Loss or Gain (as % of Total Adjusted Capitation Rate Revenue) ¹	Corresponding Risk Corridor Percentage	% Contractor Risk Sharing	% EOHHS & CMS Risk Sharing	% CMS Risk Sharing	% EOHHS Risk Sharing ²
Loss >20%	>120.0%	100%	0%	0%	0%
Loss >10% and ≤ 20%	110.1% to 120.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Loss >1% and ≤ 10%	101.1% to 110.0%	10%	90%	(90%) * (Medicare A/B Percent of Rate)	(90%)* (Medicaid Percent of Rate)

Loss or Gain ≤ 1%	99.0% to 101.0%	100%	0%	0%	0%
Gain >1% and ≤ 10%	90.0% to 98.9%	10%	90%	(90%) * (Medicare A/B Percent of Rate)	(90%)* (Medicaid Percent of Rate)
Gain >10% and ≤ 20%	80.0% to 89.9%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Gain >20%	< 80.0%	100%	0%	0%	0%

¹ Loss and gain reflected on an incremental basis, rounded to the nearest one tenth of a percent. Loss or gain >20.0% still results in risk sharing reconciliation for the loss or gain between 1.1% and 20.0%.

³ All EOHHS Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

b. Demonstration Year 2

Incremental Loss or Gain (as % of Total Adjusted Capitation Rate Revenue)¹	Corresponding Risk Corridor Percentage	% Contractor Risk Sharing	% EOHHS & CMS Risk Sharing	% CMS Risk Sharing	% EOHHS Risk Sharing²
Loss >10%	>110.0%	100%	0%	0%	0%
Loss >3% and ≤ 10%	103.1% to 110.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)

Loss or Gain ≤ 3%	97.0% to 103.0%	100%	0%	0%	0%
Gain >3% and ≤ 10%	96.9% to 90.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)*(Medicaid Percent of Rate)
Gain >10%	< 90.0%	100%	0%	0%	0%

¹ Loss and gain reflected on an incremental basis, rounded to the nearest one tenth of a percent. Loss or gain >10.0% still results in risk sharing reconciliation for the loss or gain between 3.1% and 10.0%.

² All EOHHS Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

c. Demonstration Year 3

Incremental Loss or Gain (as % of Total Adjusted Capitation Rate Revenue)¹	Corresponding Risk Corridor Percentage	% Contractor Risk Sharing	% EOHHS & CMS Risk Sharing	% CMS Risk Sharing	% EOHHS Risk Sharing²
Loss >8%	>108.0%	100%	0%	0%	0%
Loss >4% and ≤ 8%	104.1% to 108.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Loss or Gain ≤ 4%	96.0% to 104.0%	100%	0%	0%	0%
Gain >4% and ≤ 8%	95.9% to 92.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Gain >8%	< 92.0%	100%	0%	0%	0%

¹ Loss and gain reflected on an incremental basis, rounded to the nearest one tenth of a percent. Loss or gain >8.0% still results in risk sharing reconciliation for the loss or gain between 4.1% and 8.0%.

² All EOHHS Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

4. Demonstration Year 1, if the Contract is terminated prior to June 30, 2015

Incremental Loss or Gain (as % of Total Adjusted Capitation Rate Revenue)¹	Corresponding Risk Corridor Percentage	% Contractor Risk Sharing	% EOHHS & CMS Risk Sharing	% CMS Risk Sharing	% EOHHS Risk Sharing²
Loss >20%	>120.0%	100%	0%	0%	0%
Loss > 3% and ≤ 20%	103.1% to 120.0%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Loss >1% and ≤ 3%	101.1% to 103.0%	10%	90%	(90%) * (Medicare A/B Percent of Rate)	(90%)* (Medicaid Percent of Rate)
Loss or Gain ≤ 1%	99.0% to 101.0%	100%	0%	0%	0%
Gain >1% and ≤ 3%	97.0% to 98.9%	10%	90%	(90%) * (Medicare A/B Percent of Rate)	(90%)* (Medicaid Percent of Rate)
Gain > 3% and ≤ 20%	80.0% to 96.9%	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)* (Medicaid Percent of Rate)
Gain >20%	< 80.0%	100%	0%	0%	0%

¹ Loss and gain reflected on an incremental basis, rounded to the nearest one tenth of a percent. Loss or gain >20.0% still results in risk sharing reconciliation for the loss or gain between 1.1% and 20.0%.

² All EOHHS Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

4. Risk Sharing Settlement:

CMS and EOHHS shall determine interim and final settlements of payments made by the Contractor to CMS and EOHHS or by CMS and EOHHS to the Contractor under this section. Interim and final settlement amounts shall be calculated for each Demonstration Year; however, the Risk Corridor for Demonstration Year 1 as described in **Section 4.6.B.2.a** shall be contingent upon Contractor participation in the Demonstration at least through June 30, 2015, unless otherwise permitted by CMS and MassHealth; and Demonstration Year 2 payment shall be contingent upon Contractor participation in the Demonstration at least through March 31, 2016, unless otherwise permitted by CMS and MassHealth. If the Contract is terminated prior to June 30, 2015, the risk corridor shall be calculated in accordance with **Section 4.6.B.2.d**.

a. Interim Settlement: CMS and EOHHS shall determine an interim settlement based on 3 months of claims run-out beyond the end of Demonstration Year 1 and an incurred but not reported (IBNR) estimate.

(1) For the purpose of the interim settlement, the Contractor will jointly provide to CMS and EOHHS the following within 120 calendar days following the end of each Demonstration Year:

(A) A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the Demonstration Year;

- (B) A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the Demonstration Year, including 3 months of claims run-out;
 - (C) The Contractor's best estimate of any claims incurred but not reported (IBNR) for claims run-out beyond 3 months and any IBNR completion factors by category of service;
 - (D) A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. 423.514(a)(1);
 - (E) A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in **Section 4.3.B**);
 - (F) A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;
 - (G) Encounter data, as required under **Section 2.17** of this Contract, unless otherwise permitted by CMS and MassHealth; and
 - (H) A completed electronic funds transfer authorization agreement.
- (2) CMS and EOHHS shall provide the Contractor with an interim reconciliation under the risk corridor arrangement within 150 calendar days following the end of the Demonstration Year, unless otherwise permitted by CMS. Any balance due between the Contractor and CMS and EOHHS shall be paid within 60 days of the Contractor receiving the Interim Reconciliation from CMS and

EOHHS.

- (3) The Contractor shall provide any additional information upon request from CMS and EOHHS necessary to calculate Total Adjusted Expenditures.
 - (4) The Contractor may request an earlier, additional interim settlement. CMS or EOHHS, at their sole discretion, may choose to make the additional settlement. If such an additional interim settlement is made, for subsequent interim and final settlements, the parties must still comply with the requirements in this **Section 4.6.B.4.**
- b. Final Settlement: CMS and EOHHS shall determine a final settlement based on 15 months of claims run-out and an IBNR estimate.
- (1) For the purpose of the final settlement, the Contractor will jointly provide to CMS and EOHHS the following within 480 calendar days following the end of each Demonstration Year:
 - (A) A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the Demonstration Year;
 - (B) A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the Demonstration Year, including 15 months of claims run-out;
 - (C) The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond 15 months and any IBNR completion factors by category of service;

- (D) A complete and accurate report of Part D revenue and expenditure, as required under 42 CFR 423.514(a)(1);

 - (E) A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in **Section 4.3.B**);

 - (F) A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;

 - (G) Financial Reports;

 - (H) Encounter data, as required under **Section 2.17** of this Contract, unless otherwise permitted by CMS and MassHealth;

 - (I) The Contractor shall provide any additional information upon request from CMS and EOHHS necessary to calculate Total Adjusted Expenditures.
- (2) CMS and EOHHS shall provide the Contractor with a final reconciliation under the risk corridor arrangement by within 510 calendar days following the end of each Demonstration Year. Any balance due between the Contractor and CMS and EOHHS, net of any payments made for the interim settlement, shall be paid within 60 days of the Contractor receiving the final reconciliation from CMS and EOHHS; and

C. Medical Loss Ratio Requirements

For all Demonstration Years in which a risk corridor mechanism is available, the Medicare Advantage MLR requirements as per 42 C.F.R. 422 Subpart X and 42 C.F.R. 423 Subpart X, are waived. To the extent the risk corridor ceases, the prevailing Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect. Any remittances owed as a result of applying the prevailing Medicare Advantage MLR requirements would be shared between EOHHS and Medicare proportionally based on each payor's contribution to the total premiums subject to the MLR calculation. The MLR calculation shall include costs associated with Covered Services and care management as patient care, rather than administrative, costs.

4.7 Payment in Full

The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, EOHHS and the Contractor) for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

By signing this Contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Federal Government to the Contractor, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

Section 5: Additional Terms and Conditions

5.1 Administration

A. Notification of Administrative Changes

The Contractor must notify CMS and EOHHS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and EOHHS in HPMS no later than 30 calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to **Appendix D**. The Contractor must notify CMS and EOHHS in HPMS of all other changes no later than five business days prior to the effective date of such change.

B. Assignment

The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and EOHHS which may be withheld for any reason or for no reason at all.

C. Independent Contractors

1. The Contractor, its employees, First Tier, Downstream and Related Entities, 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 the federal government, EOHHS, or the Commonwealth of Massachusetts.

2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated, as provided for in **Appendix D**.

D. Subrogation

Subject to CMS and EOHHS lien and third-party recovery rights, the Contractor must:

1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;
2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:
 - a. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and
 - b. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

E. Prohibited Affiliations

In accordance with 42 U.S.C. §1396 u-2(d)(1), 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 excluded, under federal law or regulation, 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 or be permitted to serve as a director, officer, or partner of the Contractor. Federal Financial Participation (FFP) is not available for any amounts paid to an MCE that could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Act.

F. Disclosure Requirements

The Contractor must disclose to CMS and EOHHS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by EOHHS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to EOHHS in accordance with this Contract and relevant state and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act.

G. Physician Incentive Plans

1. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. The Contractor must submit all information required to be disclosed to CMS and EOHHS in the manner and format specified by CMS and EOHHS which, subject to Federal approval, must be consistent with the format required by CMS for Medicare contracts.
2. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by EOHHS that results from the Contractor's or its subcontractors' failure to comply with the requirements governing

physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and EOHHS, that it has made a good faith effort to comply with the cited requirements.

H. Physician Identifier

The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. §1320d-2(b). The Contractor must provide such unique identifier to CMS and EOHHS for each of its PCPs in the format and time-frame established by CMS and EOHHS in consultation with the Contractor.

I. Timely Provider Payments

1. The Contractor must make timely payments to its providers. The Contractor must ensure that 90% of payment claims from physicians who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within 30 days of the date of receipt of the claim. In addition, 99% of all claims from Covered Service providers will be paid within 90 days from the date the Contractor receives the claim. The Contractor and its providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.
2. Submit a claims processing annual report on timely payment to providers.

J. Protection of Enrollee-Provider Communications

In accordance with 42 U.S.C. §1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a clinical subcontractor from advising an Enrollee about

the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical subcontractor is acting within the lawful scope of practice.

K. Protecting Enrollee from Liability for Payment

The Contractor must:

1. in accordance with 42 C.F.R. 438.106, not hold an Enrollee liable for:
 - a. debts of the Contractor, in the event of the Contractor's insolvency;
 - b. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or EOHHS for such services; or
 - c. payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;
2. not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in **Appendix A**;
3. not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge; and
4. not deny any service provided under this Contract to an Enrollee who, prior to becoming an Eligible Beneficiary, incurred a bill that has not been paid.

L. Moral or Religious Objections

The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

1. to the Commonwealth;
2. with its application for a contract;
3. whenever it adopts the policy during the term of the contract; and
4. the information provided must be
 - a. consistent with the provisions of 42 C.F.R. 438.10;
 - b. provided to Eligible Beneficiaries before and during enrollment; and
 - c. provided to Enrollees within 90 days after adopting the policy with respect to any particular service.

M. Third Party Liability

1. General Requirements

a. Coordination of Benefits

- (1) EOHHS shall, via the HIPAA 834 Outbound Enrollment file, provide the Contractor with all third party health insurance information on Enrollees where it has verified that third party health insurance exists.
- (2) EOHHS shall refer to the Contractor the Enrollee's name and pertinent information where EOHHS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

b. The Contractor shall:

- (1) Designate a Third Party Liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract.
- (2) Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.
- (3) Perform Benefit Coordination in accordance with this **Section 5.1.M**. The Contractor shall work with EOHHS via interface transactions with the MMIS system using HIPAA standard formats to submit information with regard to TPL investigations and recoveries.

c. Third Party Health Insurance Information:

The Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance except Medicare Part A and B and MassHealth Standard or CommonHealth, and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:

- (1) The HIPAA 834 Outbound Enrollment File (for more information on this interface with MMIS and all interfaces, see **Section 2.16**);
- (2) Claims Activity;
- (3) Point of Service Investigation (Customer Service, Member Services and Utilization Management); and
- (4) Any TPL information self-reported by an Enrollee.

d. At a minimum, such procedures shall include:

- (1) If the Contractor also offers commercial policies or Commonwealth Care plans, the Contractor shall perform a data match within their own commercial plan or Commonwealth Care plan subscriber/member list. If an Enrollee is found to also be enrolled in the Contractor's commercial plan or Commonwealth Care plan, the Enrollee's information shall be sent to EOHHS or a designee assigned by EOHHS. EOHHS shall verify the Enrollee's enrollment and eligibility status and if EOHHS confirms that the Contractor was correct, disenroll the Enrollee for a prospective effective date and provide advance notice to the Enrollee; and
- (2) Reviewing claims for indications that other insurance may be active (e.g. explanation of benefit attachments or third party payment).

e. Third Party Health Insurance Cost-Avoidance, Pay and Recover Later and Recovery

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

The Contractor shall perform the following activities to cost-avoid, pay and recover later, or recover claims when other health insurance coverage is available:

(1) Cost-Avoidance

The Contractor shall:

- (A) On the Daily Inbound Demographic Change File provide all third party liability information on the Contractor's Enrollees;
- (B) Pend claims that are being investigated for possible third party health insurance coverage in accordance with EOHHS's guidelines;
- (C) Deny claims submitted by a provider when the claim indicates the presence of other health insurance;
- (D) Instruct providers to use the TPL Indicator Form to notify EOHHS of the potential existence of other health insurance

coverage and to include a copy of the Enrollee's health insurance card with the TPL Indicator Form if possible; and

(E) Distribute TPL Indicator Forms at the Contractor's provider orientations.

(2) Pay and Recover Later

The Contractor shall take all actions necessary to comply with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139.

(3) Recovery

The Contractor shall:

(A) Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;

(B) Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable; and

(C) Develop procedures and train staff to ensure that Enrollees who have comprehensive third party health insurance are identified and reported to EOHHS.

2. Reporting

a. Semi-annually, the Contractor shall report to EOHHS the following, in accordance with the requirements set forth in **Appendix N**:

(1) Other Insurance – the number of referrals sent by the Contractor on the Inbound Demographic Change File, and the number of Enrollees identified as having TPL on the monthly HIPAA 834 Inbound Enrollment file;

(2) Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139;

(3) Cost avoidance – the number and dollar amount of claims that were denied by the Contractor due to the existence of other health insurance coverage on a semi-annual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and

(4) Recovery - Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan, on a semi-annual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or provider.

3. Accident and Trauma Identification and Recovery Identification

a. Cost Avoidance and Recovery

The Contractor shall recover or cost avoid claims where an Enrollee has been involved in an accident or lawsuit in accordance with **Appendix N**.

b. Claims Editing and Reporting

The Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other third party liability cases:

- (1) Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;
- (2) Provider Notification – Claims where providers have noted accident involvement;
- (3) Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident; and
- (4) Questionnaires will be based on a predetermined diagnosis code range.

c. Medical Management

The Contractor shall identify any requested medical services related to motor vehicle accidents, or work related injuries, and refer these claims to the recoveries specialist for further investigation.

d. Reporting

On a semi-annual basis, the Contractor will provide EOHHS with cost avoidance and recovery information on accidents and trauma cases as specified in **Appendix N**.

N. Medicaid Drug Rebate

Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

The Contractor shall submit to EOHHS, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by the National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as EOHHS determines necessary.

5.2 Confidentiality

A. Statutory Requirements

The Contractor understands and agrees that CMS and EOHHS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R., parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under M.G.L. c. 66A. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

B. Personal Data

The Contractor must inform each of its employees having any involvement with personal data or other confidential information - whether with regard to design, development, operation, or maintenance - of the laws and regulations relating to confidentiality.

C. Data Security

The Contractor must take reasonable steps to ensure the physical security of personal data or other protected information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member or Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. §164.530(c). The Awardee must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. part 164, subpart C, the HIPAA Security Rule.

D. Return of Personal Data

The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or EOHHS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or EOHHS will destroy such data or material.

E. Destruction of Personal Data

For any PHI received regarding an Eligible Beneficiary referred to Contractor by EOHHS who does not enroll in Contractor's plan, the Contractor must destroy the PHI in accordance with standards set forth in National Institute of Science and Technology (NIST) Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable state and federal Privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time. The Contractor shall also adhere to standards described in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

F. Research Data

The Contractor must seek and obtain prior written authorization from CMS and EOHHS 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.

5.3 General Terms and Conditions

A. Applicable Law

The term "applicable law," as used in this Contract, means, without limitation, all federal and State law, and the regulations, policies, procedures, and instructions of CMS and EOHHS all as existing now or during the term of this Contract.

B. Sovereign Immunity

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Massachusetts or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

C. Advance Directives

Nothing in this Contract shall be interpreted to require an Enrollee to execute an advance directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

D. Loss of Licensure

If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary Federal or State approvals, the Contractor must report such loss to CMS and EOHHS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.5**.

E. Indemnification

The Contractor shall indemnify and hold harmless CMS, the Commonwealth of Massachusetts, the federal government, and EOHHS from and against any and all liability, loss, damage, costs, or expenses which CMS and or EOHHS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

1. the Contractor is notified of any claims within a reasonable time from when CMS and EOHHS become aware of the claim.

F. Prohibition against Discrimination

1. In accordance with 42 U.S.C. §1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor from including

providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

2. If a Complaint or claim against the Contractor is presented to the EOHHS for handling discrimination Complaints (MCAD), the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.

G. Anti-Boycott Covenant

During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, CMS and EOHHS will be entitled to rescind this Contract in the event of noncompliance with this **Section 5.3(G)**. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the Contractor.

H. Information Sharing

During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable Federal and State laws, the Contractor must arrange for the transfer, at no cost to CMS, EOHHS, or the Enrollee, of medical information regarding such Enrollee to any subsequent provider of medical services to such Enrollee, as may be requested by the Enrollee or such provider or directed by CMS and EOHHS the Enrollee, regulatory agencies of EOHHS, or the United States Government. With respect to Enrollees who are in the custody of the Commonwealth, the Contractor must provide, upon reasonable request of the State agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.

I. Other Contracts

Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor must provide CMS and EOHHS with a complete list of such plans and services, upon request. CMS and EOHHS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or EOHHS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

J. 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.

K. Entire Contract

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 will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

L. No Third-Party Rights or Enforcement

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

M. Corrective Action Plan

If, at any time, CMS and/or EOHHS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and/or EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency.

CMS and EOHHS may require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan, and demonstrate to CMS and EOHHS that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and EOHHS or other intermediate sanctions as described in **Section 5.3(N)**.

N. Intermediate Sanctions and Civil Monetary Penalties

1. In addition to termination under **Section 5.5**, CMS and EOHHS may impose any or all of the sanctions in **Section 5.3(N)** upon any of the events below; provided, however, that CMS and EOHHS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction. Sanctions may be imposed in accordance with this section if the Contractor:
 - a. fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;
 - b. imposes charges on Enrollees in excess of any permitted under this Contract;
 - c. discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;
 - d. misrepresents or falsifies information provided to CMS, Enrollees, contractors, or Network Providers;
 - e. fails to comply with requirements regarding physician incentive plans (see **Section 5.1.G**);
 - f. fails to comply with federal or State statutory or regulatory requirements related to this Contract;
 - g. violates restrictions or other requirements regarding marketing;

- h. fails to comply with quality management requirements consistent with **Section 2.13**;
- i. fails to comply with any corrective action plan required by CMS and EOHHS;
- j. fails to comply with financial solvency requirements;
- k. fails to comply with reporting requirements; or
- l. fails to comply with any other requirements of this Contract.

2. Such sanctions may include:

- a. financial penalties consistent with 42 C.F.R. § 438.704;
- b. the appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396u-2(e)(2)(B);
- c. suspension of enrollment (including assignment of Enrollees);
- d. suspension of payment to the Contractor;
- e. disenrollment of Enrollees; and
- f. suspension of marketing.

3. If CMS or EOHHS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented a corrective action plan in accordance with **Section 5.3(M)**, CMS and EOHHS may:

- a. require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and EOHHS; or

- b. require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.
4. Before imposing any intermediate sanctions, the State and CMS must give the entity timely written notice that explains the basis and nature of the sanction and other due process protections that the State elects to provide.

O. Additional Administrative Procedures

CMS and EOHHS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda as may be issued from time to time.

P. Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

Q. Conflict of Interest

Neither the Contractor nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and EOHHS with the performance of services under the Contract. Without limiting the generality of the foregoing, CMS and EOHHS require that neither the Contractor nor any First Tier, Downstream, or Related Entity has any financial, legal, contractual or other business interest in any entity performing ICO enrollment functions for EOHHS.

R. Insurance for Contractor's Employees

The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The

Contractor must, at the request of CMS or EOHHS, provide certification of professional liability insurance coverage.

S. Key Personnel

The Contractor's Senior Program Manager and/or the Executive with oversight of the Program, Chief Medical Officer/Medical Director, Pharmacy Director, Behavioral Health Director, Director of /Long Term Services and Support, ADA Compliance Director, Chief Financial Officer, Chief Operating Officer or Director of Operations, Program Quality Manager, Senior Manager of Clinical Services or equivalent position, Claims Director, IT Director, Compliance Officer, Provider Network Manager, and the designated "Key Contact" are key personnel. The Contractor shall submit to EOHHS the name, resume, and job description for each of the key personnel to EOHHS within 5 days of executing this Contract. If the Contractor substitutes another individual for any individual identified by the Contractor as key personnel, the Contractor must notify EOHHS immediately and provide the name(s) and resumes of qualified replacements.

If EOHHS is concerned that any of the key personnel are not performing the responsibilities, including but not limited to, those provided for the person's position under **Section 2.2. D.4** EOHHS shall inform the Contractor of this concern. The Contractor shall investigate said 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 the Contractor's actions fail to ensure full compliance with the terms of this Contract, as determined by EOHHS, the Corrective Action Provisions in **Section 5.3** may be invoked by EOHHS.

T. Waiver

The Contractor, CMS, or EOHHS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or EOHHS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and EOHHS of any materials including

but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

U. Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

V. Other State Terms and Conditions

Massachusetts Executive Order 504 – As a Contract entered into after January 1, 2009, the Contractor shall certify by signing Executive Order 504 Contractor Certification Form that they have read the Order Regarding the Security and Confidentiality of Personal Information, Mass. Exec. Order No. 504 (Sept. 19, 2008), that they have reviewed and will comply with all information security programs, plans, guidelines, standards and policies that apply to the work they will be performing for their contracting agency, that they will communicate these provisions to and enforce them against their First Tier, Downstream and Related Entities, and that they will implement and maintain any other reasonable and appropriate security procedures and practices necessary to protect personal information to which they are given access as part of the contract from unauthorized access, destruction, use, modification, disclosure or loss. The provisions of Executive Order 504 shall be enforced through EOHHS and the Operational Services Division (OSD). Any breach shall be regarded as a material breach of the Contract that may subject the Contractor to appropriate sanctions.

5.4 Record Retention, Inspection, and Audit

- A. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices through ten years from the end of the final Contract period or completion of audit, whichever is later.

- B. The Contractor must make the records maintained by the Contractor and its Provider Network), as required by CMS and EOHHS and other regulatory agencies, available to CMS and EOHHS and its agents, designees or contractors or any other authorized representatives of the Commonwealth of Massachusetts or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

- C. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

- D. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or EOHHS may require, in a manner that meets CMS and EOHHS's record maintenance requirements.

- E. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

5.5 Termination of Contract

A. Termination without Prior Notice

In the event the Contractor materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or MassHealth programs, CMS or EOHHS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or EOHHS may terminate the Contract in accordance with regulations that are current at the time of the termination.

Without limiting the above, if CMS or EOHHS determine that participation of the Contractor in the Medicare or MassHealth program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or MassHealth program, CMS or EOHHS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or EOHHS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Medicare-Medicaid Beneficiaries.

United States law will apply to resolve any claim of breach of this Contract.

B. Termination with Prior Notice

1. CMS or EOHHS may terminate this Contract without cause upon no less than 90 days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per **Section 5.7**, the Contractor may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a), except that in Demonstration Year 1 the Contractor may choose to non-renew before August 1 and may terminate the contract by mutual consent of CMS and EOHHS at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and EOHHS will consider, among other factors, financial performance under this Contract in granting consent for termination. Any written communications or oral scripts developed to

implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and EOHHS prior to their use.

2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph **5.5.B.1** and non-renewal of this Contract as described in **Section 5.7** to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

3. In the event that this Contract is terminated with prior notice per this **Section 5.5.B**, the Contractor shall report encounter data and performance measurement results through the effective termination date of the Contract, including but not limited to HEDIS, HOS, and CAHPS, as outlined in Section 2.13.C.1.a., unless otherwise permitted by CMS and MassHealth.

C. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

D. Termination for Cause

Any party may terminate this Agreement upon 90 days' notice due to a material breach of a provision of this Contract unless CMS or EOHHS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or EOHHS may expedite the termination.

Pre-termination Procedures. Before terminating a contract under 42 C.F.R. §422.510 and §438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or EOHHS must:

1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or
2. Notify the Contractor of its Appeal rights as provided in 42 C.F.R. §422 Subpart N and §438.710.

E. Termination due to a Change in Law

In addition, CMS or EOHHS may terminate this agreement upon 30 days' notice due to a material change in law, or with less or no notice if required by law.

F. Continued Obligations of the Parties

1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or MassHealth programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and EOHHS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

2. In the event that this Contract is terminated, expires, or is not renewed for any reason:
 - a. if CMS or EOHHS, or both, elect to terminate or not renew the Contract, CMS and EOHHS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements;
 - b. the Contractor must promptly return to CMS and EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and
 - c. the Contractor must supply to CMS and EOHHS all information necessary for the payment of any outstanding claims determined by CMS and EOHHS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6 Order of Precedence

- A. The following documents are incorporated into and made a part of this Contract, including all appendices:

1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year; and
 2. Memorandum of Understanding, a document between CMS and the Commonwealth Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Beneficiaries (August 20, 2012);
 3. the Request for Responses from Integrated Care Organizations RFR #12CBEHSDUALSICORFR
 4. the Contractor's response to the Request for Responses from Integrated Care Organizations RFR #12CBEHSDUALSICORFR.; and
 5. any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties.
- B. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:
1. the Contract terms and conditions, including all appendices;
 2. Capitated Financial Alignment Application;
 3. Memorandum of Understanding, a document between CMS and the Commonwealth Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Beneficiaries (August 20, 2012);

4. the Request for Responses from Integrated Care Organizations RFR #12CBEHSDUALSICORFR;
 5. the Contractor's response to the Request for Responses from Integrated Care Organizations RFR #12CBEHSDUALSICORFR; and
 6. any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties.
- C. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.7 Contract Term

This Contract shall be in effect through December 31, 2016, and, so long as the Contractor has not provided CMS with a notice of intention not to renew, and CMS/EOHHS have not provided the Contractor with a notice of intention not to renew, pursuant to 42 C.F.R. 422.506 or **Section 5.5** above, shall be renewed in one year terms, through December 31, 2016.

5.8 Amendments

The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory,

regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of all parties, and attached hereto.

5.9 Written Notices

Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services

Medicare-Medicaid Coordination Office

7500 Security Boulevard, S3-13-23

Baltimore, MD 21244

Copies to:

To: Executive Office of Health and Human Services

1 Ashburton Place, Suite 1109

Boston, MA 02108

Copies to:

To: [Contractor]

[Address]

Copies to:

In Witness Whereof, CMS, EOHHS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

[Contractor]

(Authorized Signatory) (Title)

(Signature) (Date)

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

(Authorized Signatory) (Title)

(Signature) (Date)

(Authorized Signatory) (Title)

(Signature) (Date)

Executive Office of Health and Human Services, Commonwealth of Massachusetts

(Authorized Signatory) (Title)

(Signature) (Date)

Section 6: Appendices

APPENDIX A - COVERED SERVICES

A. Medical Necessity

The Contractor shall provide services to Enrollees as follows:

1. Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in **Section 2.4**, in accordance with the requirements of the Contract.
2. Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:
 - a. Prevent, diagnose, or treat health impairments;
 - b. Attain, maintain, or regain functional capacity.
3. Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.
4. Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.
5. The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:
 - a. Developed with input from practicing physicians in the Contractor's Service Area;
 - b. Developed in accordance with standards adopted by national accreditation organizations;
 - c. Developed in accordance with the definition of Medical Necessity in **Section 2**;
 - d. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
 - e. Evidence-based, if practicable; and
 - f. Applied in a manner that considers the individual health care needs of the Enrollee.
6. The Contractor's Medical Necessity guidelines, program specifications and service components for Behavioral Health Services must, at a minimum, be

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

7. The Contract must offer to Enrollees any additional non-medical programs and services available to a majority of the Contractor's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by EOHHS and the Contractor, such as health club discounts, diet workshops and health seminars.

B. Covered Services

1. Contractor agrees to provide Enrollees access to the following Covered Services:
 - a. All services provided under Medicare Part A
 - b. All services provided under Medicare Part B
 - c. All services provided under Medicare Part D
 - d. Pharmacy products that are covered by MassHealth and may not be covered under Medicare Part D and drugs excluded from Medicare Part D; including over-the-counter drugs and prescription vitamins and minerals as specified in the MassHealth Drug List. Contractors are encouraged to offer a broader drug formulary than minimum requirements.
 - e. All services listed and defined in Appendix B, Exhibits 1, 2, 3 and 4, below.

C. Cost-sharing for Covered Services

1. Except as described below, cost-sharing of any kind is not permitted in this Demonstration.
2. For all pharmacy products included in the Covered Services, the Contractor may charge co-pays equal to no more than the lower of:
 - a. the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low-Income Subsidy; or
 - b. the applicable MassHealth co-pay amounts.
3. In addition, the Contractor must institute a cap on out-of-pocket pharmacy co-pay expenses for a calendar year consistent with MassHealth policy. In 2012, this cap is \$250; this amount may change during the Demonstration. All pharmacy co-pays paid by the Member under the ICO pharmacy benefit will count toward this cap.

4. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

APPENDIX B - COVERED SERVICES DEFINITIONS

Exhibit 1: General Services

Adult Day Health - community-based services such as nursing, assistance with activities of daily living, social, therapeutic, recreation, nutrition at a site outside the home, and transportation to a site outside the home.

Adult Foster Care - daily assistance in personal care, managing medication, meals, snacks, homemaking, laundry, and medical transportation.

Ambulance - the provision of transportation in an ambulance for medical reasons

Ambulatory Surgery/Outpatient Hospital Care - all outpatient surgical services and related diagnostic medical and services.

Audiologist - audiologist exams and evaluations. See related hearing aid services.

Behavioral Health Inpatient Services - twenty-four-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both, including:

1. Inpatient Mental Health Services — hospital services to stabilize an acute psychiatric condition that: 1) has a relatively sudden onset; 2) has a short, severe course; 3) poses a significant danger to self or other; or 4) has resulted in marked

psycho-social dysfunction or grave mental disability.

2. Inpatient Substance Use Disorder Services (Level IV)
3. Observation/Holding Beds
4. Administratively Necessary Day Services

Behavioral Health Outpatient Services – Mental health and substance use disorder services provided in person in an ambulatory care setting such as a mental health center or substance use disorder clinic, hospital outpatient department, community health center, or practitioner’s office. The services may be provided at an Enrollee’s home or school:

1. Family Consultation
2. Case Consultation
3. Diagnostic Evaluation
4. Psychiatric Consultation on an Inpatient Medical Unit
5. Medication Visit
6. Couples/Family Treatment
7. Group Treatment
8. Individual Treatment
9. Inpatient-Outpatient Bridge Visit
10. Acupuncture Treatment
11. Opioid Replacement Therapy
12. Ambulatory Detoxification (Level II.d)
13. Psychological Testing

Chiropractic Services – chiropractic manipulative treatment and radiology services.

Community Health Center Services - provided by a freestanding institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111 s. 51 that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, and administers its own budget and personnel. A Community Health Center must be a non-profit organization and must be open for the delivery of medical services to the public on a regular schedule for a minimum of 20 hours per week. A Community Health Center must provide internal medicine, pediatric, and obstetrics/gynecology services, unless approved otherwise by MassHealth, as well as health education, medical social services and nutrition services. A Community Health Center must provide other medical services on site or, alternatively, through a referral network.

Day Habilitation - — a structured, goal-oriented, active treatment program of medically oriented, therapeutic and habilitation services for individuals with developmental disabilities who need active treatment.

Dental Services – preventive, restorative, and emergency oral health services.

Durable Medical Equipment and Medical/Surgical Supplies (see also Exhibit 3) –

1. Durable Medical Equipment - products that: (a) are fabricated primarily and customarily to fulfill a medical purpose; (b) are generally not useful in the absence of illness or injury; (c) can withstand repeated use over an extended period of time; and (d) are appropriate for home use. Includes but not limited to the purchase of medical equipment, replacement parts, and repairs for such items as: canes, crutches, wheelchairs (manual, motorized, custom fitted, & rentals), walkers, commodes, special beds, monitoring equipment, and the rental of Personal Emergency Response Systems (PERS).
2. Medical/Surgical Supplies - medical/treatment products that: (a) are fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) are used in the treatment of a specific medical condition; and (c) are non-reusable and disposable including, but not limited to, items such as urinary catheters, wound dressings, and diapers.

Family Planning – family planning medical services, family planning counseling services, follow-up health care, outreach, and community education.

Group Adult Foster Care - services ordered by a physician delivered to an Enrollee in a group housing residential setting such as assisted living, elderly, subsidized or supportive housing. Group Adult Foster Care services are based upon an individual plan of care and include: assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and other personal care as needed, nursing services and oversight and care management. Assistance with ADLs, IADLs and other personal care is provided by a direct care worker that is employed or contracted by the Group Adult Foster Care Provider, Nursing services and oversight and care management are provided by a multidisciplinary team.

Hearing Aid Services – including but not limited to diagnostic services, hearing aids or instruments, and services related to the care and maintenance of hearing aids or instruments.

Home Health – all home health care services, including DME associated with such services; part-time or intermittent skilled nursing care and home health services; physical, occupational, and speech language therapy; and medical social services.

Hospice – a package of services such as nursing; medical social services; physician; counseling, including bereavement, dietary, spiritual, or other types of counseling; physical, occupational, and speech language therapy; homemaker/home health aide; medical supplies, drugs, biological supplies; and short term inpatient care.

Independent Nursing – continuous skilled nursing services to individuals living in the community

Inpatient Hospital Services— all inpatient services, including but not limited to physician, surgery, radiology, nursing, laboratory, other diagnostic and treatment procedures, blood and blood derivatives, semi-private or private room and board, drugs and biologicals, medical supplies, durable medical equipment, and medical surgical/intensive care/coronary care unit, as necessary, at any of the following settings:

1. acute inpatient hospital;
2. chronic hospital;
3. rehabilitation hospital; or
4. psychiatric hospital.

Laboratory - all services necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of Enrollees.

Medically Necessary non-Emergency Transportation - the provision of transportation on a non-emergency basis where medically necessary for the Enrollee.

Nurse Midwife Services - services provided by a certified nurse-midwife authorized to practice under Massachusetts General Law, in accordance with regulations promulgated by the board and the commissioner of public health, and consistent with the standards of care established by the American College of Nurse-Midwives.

Nurse Practitioner Services - services provided by a licensed nurse practitioner in accordance with all applicable federal and state laws and regulations.

Orthotics – braces (non dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body.

Oxygen and Respiratory Therapy Equipment – ambulatory liquid oxygen systems and refills; aspirators; compressor-driven nebulizers; intermittent positive pressure breather (IPPB); oxygen; oxygen gas; oxygen-generating devices; and oxygen therapy equipment rental.

Personal Care Attendant Services (Self-directed PCA) - physical assistance with Activities of Daily Living (ADLs), including but not limited to bathing, dressing, grooming, eating, ambulating, toileting, and transferring; and Instrumental Activities of Daily Living (IADLs), including but not limited to household management tasks, meal preparation, and transportation to medical providers.

Pharmacy Covered Product – The term Pharmacy Covered Product means:

1. Any drug or biological that is used for a medically-accepted indication (as that term is defined in section 1860D-2(e)(4) of the Act), and that is one of the following:
 - a) A drug that may be dispensed only on a prescription and that is described in subparagraph (A)(i), (A)(ii), or (A)(iii) of section 1927(k)(2) of the Act;
 - b) A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Act; or
 - c) Insulin described in section 1927(k)(2)(C) of the Act, and medical supplies associated with the delivery of insulin.
2. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
3. Any drug or biological that would be covered, as prescribed and dispensed or administered, under Medicare Parts A or B.

4. Drugs excluded from Medicare Part D and over-the-counter products contained in the MassHealth Drug List.
5. Prescription vitamins and minerals contained in the MassHealth Drug List.
6. The products dronabinol, megestrol, oxandrolone, and somatropin for indications not covered by Part D but covered under MassHealth.
7. Non-drug OTC products contained in the MassHealth Non-Drug Product List that are not covered by Medicare Part B or Part D, including: Hyper-Sal (sodium chloride 7% for inhalation) and urine glucose testing reagent strips used for the management of diabetes.

Exclusions -- The definition of Pharmacy Covered Product excludes the following drugs or biologicals or classes of drugs or biologicals, or their medical uses, unless otherwise specified in the MassHealth Drug List or MassHealth Non-Drug Product List:

1. Agents when used for anorexia, weight loss or weight gain;
2. Agents when used to promote fertility;
3. Agents when used for cosmetic purposes;
4. Agents when used for the symptomatic relief of cough and colds;
5. Prescription vitamins and mineral products;

6. Drugs that the manufacturer seeks to require as condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and

7. Agents when used for the treatment of sexual or erectile dysfunction.

Physician (primary) – annual exams and continuing care, including medical, radiological, laboratory, anesthesia and surgical services.

Physician (specialty) – physician specialty services, including but not limited to the following list and second opinions upon the request of the Enrollee:

Anesthesiology

Audiology

Cardiology

Dentistry

Dermatology

Gastroenterology

Gynecology

Internal Medicine

Nephrology

Neurology

Neurosurgery

Oncology

Ophthalmology

Oral surgery
Orthopedics
Otorhinolaryngology
Podiatry
Psychiatry
Pulmonology
Radiology
Rheumatology
Surgery
Thoracic surgery
Vascular surgery
Urology

Podiatry - care for medical conditions affecting the lower limbs, including routine foot care as defined by Medicare in Part III, Section 2323 of the Medicare Carriers Manual.

Prosthetics Services and Devices - prosthetic devices, including the evaluation, fabrication, and fitting of a prosthesis. Coverage includes related supplies, repair, and replacement.

Radiology and Diagnostic Tests - all X-rays, including portable X-rays, magnetic resonance imagery (MRI), radiation therapy, and radiological services.

Renal Dialysis Services - including: laboratory; prescribed drugs; tubing change; adapter change; hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis; and training related to dialysis services.

Skilled Nursing Facility - a wide range of services that result in individuals achieving or maintaining their "highest practicable" physical, mental, and psychosocial well-being. The services offered include 24 hour per day skilled nursing care; rehabilitative care, such as physical, occupational, speech, and respiratory therapy; and, assistance with ADLs such as dressing and eating; pharmaceutical services; dietary and nutritional services; all psychosocial services such as mental health and therapeutic activities; and room and board.

Speech and Hearing Services - evaluation and treatment of speech and hearing disorders.

Therapy - individual treatment, (including the design, fabrication, and fitting of an orthotic, prosthetic, or other assistive technology device); comprehensive evaluation; and group therapy.

- 1) Physical: evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems.
- 2) Occupational: evaluation and treatment designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.
- 3) Speech and Hearing: evaluation and treatment of speech language, voice, hearing, and fluency disorders.

Tobacco Cessation Services – face-to-face individual and group tobacco cessation counseling as defined at 130 CMR 433.435(B), 130 CMR 405.472 and 130 CMR 410.447 and pharmacotherapy treatment, including nicotine replacement therapy (NRT). This is in addition to any services that are covered by Medicare.

Vision Care Services – the professional care of the eyes for purposes of diagnosing and treating all pathological conditions. They include eye examinations, vision training, prescriptions, and glasses and contact lenses.

APPENDIX B - COVERED SERVICES DEFINITIONS

Exhibit 2: Behavioral Health Diversionary Services

Behavioral Health Diversionary Services are those mental health and substance use disorder services that are provided as clinically appropriate alternatives to Behavioral Health Inpatient Services, or to support an Enrollee returning to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community.

Community Crisis Stabilization – services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Enrollees who do not require Inpatient Services.

Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7) – 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Enrollees with Co-Occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs.

Clinical Support Services for Substance Use Disorders (Level III.5) – 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Enrollees with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.

Community Support Program (CSP) - an array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Enrollees with a long standing history of a

psychiatric or substance use disorder and to their families, or to Enrollees who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee.

Partial Hospitalization (PHP) - an alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include daily psychiatric management.

Psychiatric Day Treatment - services which constitute a program of a planned combination of diagnostic, treatment and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization.

Structured Outpatient Addiction Program (SOAP) - clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24-hour monitoring.

Intensive Outpatient Program (IOP) - a clinically intensive service designed to improve Functional Status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment.

Program of Assertive Community Treatment - A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Enrollees to maximize their recovery, ensure Consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the Enrollees served become better integrated into the community. Services are provided in the community and are available, as needed by the Enrollee, 24 hours a day, seven days a week, 365 days a year.

Emergency Services Program (ESP) - services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis.

APPENDIX B - COVERED SERVICES DEFINITIONS

Exhibit 3: Expansions of Services

Durable Medical Equipment (DME) - Environmental Aids and Assistive/Adaptive Technology

Durable Medical Equipment - Training in Usage, Repairs, and Modifications

Personal Assistance Services - Cueing and Monitoring

APPENDIX B - COVERED SERVICES DEFINITIONS

Exhibit 4: New Community-based Services

1. **Day Services** that provide for on-site structured day activity typically for Enrollees with pervasive and extensive support needs who are not ready to join the general workforce.
 - a. Such day services are individually designed around Consumer choice and preferences with a focus on improvement or maintenance of the person's skills and their ability to live as independently as possible in the community;
 - b. Such services often include assistance to learn activities of daily living and functional skills; language and communication training; compensatory, cognitive, and other strategies; interpersonal skills; prevocational skills; and recreational/socialization skills.

2. **Home Care Services** provided within the Enrollee's home or in the community. Such services include several types of home supports, including:
 - a. Providing a worker or support person to perform general household tasks such as preparing meals, doing laundry and routine housekeeping, and/or to provide companionship to the member;
 - b. Providing a range of personal support and assistance to enable an Enrollee to accomplish tasks that they would normally do for themselves if they could, including such things as help with bathing, dressing, personal hygiene and other activities of daily living. Such assistance may take the form of hands-on assistance or cueing and supervision to prompt the Enrollee to perform a task;
 - c. Providing a variety of activities to help the Enrollee acquire, retain, or improve his/her skills related to personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community. This may include skills training and education in self-determination and self-advocacy to enable the Enrollee to acquire skills to exercise control and responsibility over the services and supports they receive, and to become more independent, integrated, and productive in their communities; and
 - d. Requires all such home care services/supports to be appropriate when the Enrollee needs them and/or when the person who is regularly responsible for the activities, such as a family caregiver, is absent or unable to manage the tasks.

3. **Respite Care** services provided within the Enrollee's home or in locations such as hospitals, rest homes, nursing facilities, assisted living residences, adult day health or adult foster care.
 - a. Such services include services provided to an Enrollee to support his/her caregiver (family member, friend); and

- b. Such services may be provided to relieve informal caregivers from the daily stresses and demands of caring for an Enrollee in order to strengthen or support the informal support system.
4. **Peer Support/Counseling/Navigation** services within an Enrollee's home or community.
 - a. The Enrollee must be an active participant in the Comprehensive Assessment process.
 - b. Such services may be provided in small groups or may involve one peer providing support to another peer to promote and support the Enrollee's ability to participate in self-advocacy. The one-to-one peer support is instructional; it is not counseling;
 - c. Such services enhance the skills of the Enrollee to function in the community and/or family home.
 5. **Care Transitions Assistance** provided across facility and community settings. Such services facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for Enrollees who have experienced or are expecting an inpatient stay, such as:
 - a. Ensuring appropriate two-way exchange of information about the Enrollee, including:
 - i. Primary diagnoses and major health problems;
 - ii. Care plan that includes Enrollee goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable);
 - iii. Enrollee's goals of care, advance directives, and power of attorney;
 - iv. Emergency plan and contact number and person;
 - v. Reconciled medication list;
 - vi. Identification of, and contact information for, transferring clinician/institution;
 - vii. Patient's cognitive and Functional Status;
 - viii. Follow-up appointment schedule with contact information;
 - ix. Formal and informal caregiver status and contact information;
 - x. Designated community-based care provider, long-term services, and social services as appropriate.
 - xi. Telephonic or other follow-up with Enrollees within 48 hours of an inpatient encounter;
 - xii. Culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;
 - xiii. Patient-centered self-management support and relevant information specific to the Enrollee's condition and any ongoing risks; and
 - xiv. Referral to and care coordination with post-acute and outpatient providers as needed, including community-based support services providers.

6. **Home Modifications** that are physical adaptations to an Enrollee's private residence that are necessary to ensure the health, welfare and safety of an Enrollee or that enable the Enrollee to function with greater independence in the home.
 - a. Such modifications include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies required for the Enrollee.
 - b. Excluded from covered home modifications are those modifications or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the Enrollee, or which would normally be considered the responsibility of the landlord.
 - c. Home modifications that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

7. **Community Health Workers** who apply their unique understanding of experience, language, and/or culture of the populations they serve in order to carry out one or more of the following roles:
 - a. Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers;
 - b. Bridging/culturally mediating between individuals, communities, and health and human services, including actively building individual and community capacity; The Enrollee must be an active participant in the Comprehensive Assessment process. Assuring that people access the services they need;
 - c. Providing direct services, such as informal counseling, social support, care coordination, and health screenings; and
 - d. Advocating for individual and community needs.
 - e. Such workers are distinguished from other health professionals because they are hired primarily for their understanding of the populations and communities they serve; conduct outreach a significant portion of the time on one or more of the categories above; and have experience providing services in community settings.

8. **Medication Management** provided in the Enrollee's home to support the Enrollee capable of self-administration of prescription and over-the-counter medications, including the following activities provided by the support worker:
 - a. Reminding the Enrollee to take the medication;
 - b. Checking the package to ensure that the name on the package is that of the Enrollee;
 - c. Observing the Enrollee taking the medication; and

- d. Documenting in writing the observation of the Enrollee's actions regarding the medication (e.g., whether the Enrollee took or refused the medication, date and time); and
 - e. If requested by the Enrollee, opening the prepackaged medication or open containers, read the name of the medication and the directions on the label to the Enrollee, and responds to any questions the Enrollee may have regarding those directions.
9. **Non-Medical Transportation** services within the community to enable the Enrollee to access community services, activities and resources in order to foster the Enrollee's independence and support integration and full participation in his/her community.

APPENDIX C - ENROLLEE RIGHTS

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status, and language needs. The Contractor must comply with any applicable federal and state laws that pertain to Enrollee rights. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. § 422 Subpart C, and the state Memorandum of Understanding (MOU). Specifically, enrollees must be guaranteed:

- A. The right to be treated with dignity and respect.
- B. The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
- C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
- D. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition, Functional Status, and language needs.
- E. The right not to be discriminated against based on 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.
- F. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
- G. Access to an adequate network of primary and specialty providers who are appropriately qualified and capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting, as well as access to an ongoing source of primary care.
- H. The right to receive a second opinion on a medical procedure and have the Contractor pay for the second opinion consultation visit.
- I. The right to choose a plan and provider at any time, including a plan outside of the Demonstration, and have that choice be effective the first calendar day of the following month.
- J. The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this three-way Contract.
- K. The right to be furnished Covered Services in accordance with this Contract.

- L. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility and a 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 must be appropriately informed and supported to this end. Specifically, Enrollees must:
 - a. Receive an in-person Comprehensive Assessment upon enrollment in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordinating Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
 - b. Receive complete and accurate information on his or her health and Functional Status from the interdisciplinary team.
 - c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's Functional Status, and language and cultural needs. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible to the Enrollee or Enrollee's representative. Information must be available:
 - i. Before enrollment.
 - ii. At enrollment.
 - iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
 - d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
 - e. Have advance directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§ 489.100 and 489.102.
 - f. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
 - g. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.
- M. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
- N. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

- O. The right to freely exercise his or her rights, and to be assured that exercising those rights will not adversely affect the way the Contractor and its providers or the State Agency treat the Enrollee.
- P. The right to receive the information required pursuant to the Contract;
- Q. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 42 C.F.R. § 438.10(g).
- R. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
- S. The right not to be charged any cost sharing for Medicare Parts A and B services.

APPENDIX D – RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

- A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor’s behalf related to the operation of the plan offered by the Contractor are in compliance with 42 C.F.R. §§ 422.504, 423.505, and 438.6(l).
- B. Contractor shall specifically ensure:
1. Prior to contracting with any First Tier, Downstream and Related Entities, the Contractor has evaluated their ability to perform the activities to be subcontracted;
 2. That it monitors the First Tier, Downstream or Related Entities performance on an ongoing basis and performs an annual review per EOHHS requirements. If any deficiencies or areas for improvement are identified, the Contractor shall require the First Tier, Downstream or Related Entity to take corrective action. Upon request, the Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result;
 3. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
 4. HHS’s, the Comptroller General’s, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
1. Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
 2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor’s contractual obligations to CMS and EOHHS;
 3. Language that specifies the delegated activities and reporting requirements;
 4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, EOHHS, or the Contractor determine that such parties have not performed satisfactorily;

5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis;
 6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records;
 7. Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions, including the confidentiality and disclosure of medical records, or other health and enrollment information for providers; and
 8. Language that specifies First Tier, Downstream and Related Entities shall maintain liability protection sufficient to protect itself against any losses arising from any claims against itself or any provider, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance.
- D. In contracts or arrangements with First Tier, Downstream and Related Entities, the Contractor also shall include stipulations that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the First Tier, Downstream or Related Entities is based.
- E. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or
 2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.
- F. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of medical or pharmacy providers must include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.
- G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that neither the Contractor nor the provider has the right to terminate the contract without cause and shall require the provider to assist with transitioning Enrollees to new medical providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the Contractor or Enrollee.
- H. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.
- I. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:
1. Language that the Contractor is obligated to make timely payments to contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision,

the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;

2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
3. Language that medical providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;
4. Language that medical providers maintain Enrollee records and information in an accurate and timely manner;
5. Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them;
6. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees;
7. Language that states that medical providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable;
8. Language that clearly state the medical providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA;
9. Language that states medical providers are prohibited from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees;
10. Language that states the Contractor is prohibited from refusing to pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
 - a. Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or
 - b. Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient;
11. Language that states the medical provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions;
12. Language that states the medical provider must comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services;
13. Language that states the Contractor shall notify medical providers in writing of modifications in payments, modifications in Covered Services or modifications in

the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Contractor and the provider or unless such change is mandated by CMS or EOHHS without 30 days prior notice.

- a. Language that states the Contractor shall not make payment to a medical provider for a Provider Preventable Condition; and
- b. As a condition of payment, the provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the Contractor. The provider shall comply with such reporting requirements to the extent the Provider directly furnishes services; and

14. Language that states all First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003. Specifically, Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment made directly or indirectly to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Enrollee. Contractor shall ensure its First Tier, Downstream and Related Entities comply with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the Contractor's First Tier, Downstream and Related Entities that does not comply with such provisions.

J. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

K. Contractor shall not acquire established networks, excluding pharmacy networks, without executing a provider contract with each provider that complies with all of the provisions of this Appendix D and any other applicable provisions of this Contract, and contacting each provider to ensure that the provider understands the requirements of this three-way Contract and agrees to fulfill all terms of the provider contract. In provider organizations where the organization represents the provider in business decisions (e.g. a medical group or health center), a provider contract with the provider organization shall be sufficient to satisfy this requirement. The Commonwealth reserves the right to confirm and validate,

through both the collection of information and documentation from the Contractor and on-site visits to Network Providers, the existence of a contract between the Contractor and each individual provider in the Provider Network. The Contractor shall:

1. Maintain all provider contracts and other agreements and subcontracts relating to this three-way Contract in writing. All such agreements and subcontracts shall fulfill all applicable requirements of 42 C.F.R. Part 438, and shall contain all relevant provisions of this three-way Contract appropriate to the subcontracted service or activity. Without limiting the generality of the foregoing, the Contractor shall ensure that all provider contracts include the following provision: "Providers shall not seek or accept payment from any Enrollee for any Covered Service rendered, nor shall providers have any claim against or seek payment from the Commonwealth for any Covered Service rendered to an Enrollee. Instead, providers shall look solely to the (Contractor's name) for payment with respect to Covered Services rendered to Enrollees. Furthermore, providers shall not maintain any action at law or in equity against any Enrollee or the Commonwealth to collect any sums that are owed by the (Contractor's name) under the Contract for any reason, even in the event that the (Contractor's name) fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where "Contract" refers to the agreement between the Contractor and any Network Providers and non-Network Providers)." The provider contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.
2. Actively monitor the quality of care provided to Enrollees under any provider contracts and any other subcontracts;
3. Remain fully responsible for meeting all of the terms and requirements (including all applicable state and federal regulations) of the three-way Contract regardless of whether the Contractor subcontracts for performance of any three-way Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the three-way Contract;
4. Monitor and ensure that all utilization management activities provided by a First Tier, Downstream Tier, Downstream, or Related Entity comply with all provisions of this three-way Contract.
5. Ensure that all provider contracts, excluding pharmacy provider contracts, prohibit providers from billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments. Such

provider contracts shall require providers to work with Enrollees and the Contractor to assist Enrollees in keeping their appointments; and

6. Ensure that provider contracts prohibit providers from refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a Member.

L. Nothing in this section shall be construed to restrict or limit the rights of the Contractor to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

M. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities will note the following; No First Tier, Downstream or Related Entities shall for the duration of the Contract, have any interest that will conflict, as determined by EOHHS, with the performance of services under the Contract. Without limiting the generality of the foregoing, EOHHS requires that no such related entity have any financial, legal, contractual or other business interest in any entity performing ICO enrollment functions for EOHHS.

APPENDIX E - QUALITY IMPROVEMENT PROJECT REQUIREMENTS

The Contractor shall undertake the following quality improvement initiatives with the goal of identifying areas in need of improvement and undertaking quality improvement activities in response to the findings related to each initiative. QI initiatives will be submitted using the format and submission guidelines specified by EOHHS and CMS in annual guidance provided for the upcoming contract year.

1. Emergency Department (ED) utilization. The goal of this initiative is to better understand reasons for ED utilization among ICO Enrollees, and the impact of Long-Term Services and Supports (LTSS) to such usage.
 - The Contractor shall identify a random sample of a minimum of 20 members each year who have utilized ED services.
 - The Contractor shall engage an independent quality assurance entity to conduct interviews with each Enrollee in the sample to determine background and causes for ED visits, using a semi-structured interview tool provided by EOHHS.
 - The Contractor shall analyze results of the survey in order to understand the underlying causes of ED utilization for their Enrollees, including the use of and/or or failure of LTSS or whether there was a lack of appropriate LTSS to adequately support the Enrollee in his or her environment. The Contractor will identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency department services and shall implement such improvements.
 - The Contractor will report its results to EOHHS and to CMS.

2. IL-LTSS Coordinator. The goal of this initiative is to better understand the use of IL-LTSS Coordinators by ICO Enrollees.

- The Contractor shall identify a random sample of a minimum of 20 members each year who will be interviewed about use of an IL-LTSS Coordinator during that year.
- An independent quality assurance entity shall conduct interviews of each Enrollee in the sample to determine his or her experience with an IL-LTSS Coordinator, using a semi-structured interview tool provided by EOHHS.
- The Contractor shall analyze results of its survey in order to understand Enrollee experience with an IL-LTSS Coordinator, and to identify best practices as well as to understand the underlying reasons why Enrollees are or are not engaged with IL-LTSS Coordinators. The ICO will identify issues within its enrollment and assessment processes which require change and shall implement such improvements.
- The Contractor will report its results to EOHHS and to CMS.

3. Barriers to Health Access. The goal of this initiative is to better understand access issues experienced by ICO Enrollees.

- The Contractor shall identify a random sample of a minimum of 20 members each year.
- An independent quality assurance entity shall conduct interviews with each Enrollee in the sample, using a semi-structured interview tool provided by EOHHS, to determine if the Enrollees experienced any barriers to health care and, if so, to understand the nature of those barriers. Examples of barriers include, but are not limited to, the following: inaccessible medical equipment in provider offices, inaccessible signage in provider offices (i.e. no Braille writing on signs), inaccessible

communication from the Contractor or providers (i.e. no access to ASL interpreters, no written communication in large print or plain language, or no access to someone who can explain information), inadequate access to appropriate physicians for intellectually disabled Enrollees, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

- The Contractor shall analyze results of its survey in order to understand the underlying causes of these barriers to health care access. The Contractor shall identify issues within its system of care that require improvement to promote access and ADA compliance and shall implement such improvements.

 - The Contractor will report results to EOHHS and to CMS.
4. Other topic areas to be identified through annual guidance by CMS and EOHHS in accordance with 42 C.F.R. § 422.152(c) and 422.152(d).

**APPENDIX F -
ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT
TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG
PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as “CMS”) and [CONTRACT NAME] the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (EOHHS), and a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract [CONTRACT ID] governing Contractor’s operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as “the Act”) to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Article I

Voluntary Medicare Prescription Drug Plan

- A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 [(hereinafter collectively referred to as “the addendum”). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.
- B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.
- C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.
- D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, the Commonwealth, and CMS.

Article II

Functions to be Performed by Contractor

A. ENROLLMENT

1. Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have elected to enroll in Contractor's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).
2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the Contract year as provided in 42 C.F.R. §423.505(o).

3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:
 - (a) Addressing and resolving Complaints in the CMS Complaint tracking system; and

 - (b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and EOHHS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, EOHHS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.
2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has

been approved by CMS and EOHHS (as defined in **Appendix K**) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and EOHHS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.
2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. §423.329(b)(3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost

of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.
3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

Article III

Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND EOHHS LICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and EOHHS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV

HIPAA Provisions

- A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. §423.136.

- B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V

Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2016. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—
 - (a) Contractor has not provided CMS or EOHHS with a notice of intention not to renew in accordance with Article VII of this addendum, and
 - (b) CMS or EOHHS has not provided Contractor with a notice of intention not to renew.
2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and EOHHS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VI

Nonrenewal of Addendum

A. NONRENEWAL BY CONTRACTOR

Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VII

Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VIII

Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article IX

Termination of Addendum by Contractor

- A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.

- B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article X

Relationship between Addendum and Capitated Financial Alignment Contract

- A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment Contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this Contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

- B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment Contract to which this document is an addendum.

- C. In the event that Contractor's Capitated Financial Alignment Contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, Contractor, EOHHS and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI

Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

Article XII

Severability

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

Article XIII

Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND EOHHS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and EOHHS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not

limited to, establishing and successfully testing connectivity with CMS and EOHHS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

- E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

- F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

APPENDIX G - DATA USE ATTESTATION

The Contractor shall restrict its use and disclosure of Medicare data obtained from CMS and EOHHS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and EOHHS to administer. The Contractor shall only maintain data obtained from CMS and EOHHS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and EOHHS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or EOHHS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and EOHHS.

The Contractor further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Beneficiaries to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Medicare-Medicaid Beneficiaries information about non-health related services after obtaining consent from the members. Second, the Contractor may provide information about health-related services without obtaining prior member consent, as long as the Contractor affords the member an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Beneficiaries beyond the scope for which CMS and the Commonwealth have authorized under this agreement. A termination of this data use agreement may result in CMS or EOHHS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an Integrated Care Organization (ICO). This agreement shall remain in effect as long as the Contractor remains an ICO sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or EOHHS make available to the general public on their websites.

APPENDIX H - APPLICABLE DATA USE ATTESTATION INFORMATION SYSTEMS

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)

Common Medicare Environment (CME)

Common Working File (CWF)

Coordination of Benefits Contractor (COBC)

Drug Data Processing System (DDPS)

Electronic Correspondence Referral System (E CRS)

Enrollment Database (EDB)

Financial Accounting and Control System (FACS)

Front End Risk Adjustment System (FERAS)

Health Plan Management System (HPMS), including Complaints Tracking and all other modules

HI Master Record (HIMR)

Individuals Authorized Access to CMS Computer Services (IACS)

Integrated Data Repository (IDR)

Integrated User Interface (IUI)

Medicare Advantage Prescription Drug System (MARx)

Medicare Appeals System (MAS)

Medicare Beneficiary Database (MBD)

Payment Reconciliation System (PRS)

Premium Withholding System (PWS)

Prescription Drug Event Front End System (PDFS)

Retiree Drug System (RDS)

Risk Adjustments Processing Systems (RAPS)

APPENDIX I - MODEL FILE & USE CERTIFICATION FORM

Pursuant to the Contract between the Centers for Medicare & Medicaid Services (CMS), the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (EOHHS), and [insert organization name], hereafter referred to as the Contractor, governing the operations of the following health plan: [insert health plan name and Contract number], the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or EOHHS to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. §422.2260 – §422.2276 and 42 C.F.R. §422.111 for ICOs and the Medicare Marketing Guidelines.

I agree that CMS or EOHHS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and EOHHS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor

APPENDIX J -- Medicare MARK LICENSE AGREEMENT

THIS AGREEMENT is made and entered into December 28, 2015

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),

with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

[Contractor] (hereinafter "Licensee"),

with offices located at [Address]

CMS Contract ID: [Contract ID #]

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning <DATE>.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2016 concurrent with the execution of the Part D addendum to the three-way Contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark

immediately. Starting December 31, 2014 this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration Contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

APPENDIX L – FOUNDATIONAL ELEMENTS OF PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION

The following are the foundational elements that signify integration of primary care and behavioral health in each of five practice areas or domains of care delivery. These elements were defined by the Massachusetts Patient-Centered Medical Home Initiative (PCMHI) Behavioral Health Work Group in consultation with Mountainview Consulting and Work Group member Dr. Alexander Blount, as essential for a Primary Care Provider to effectively integrate Behavioral Health Services.

I. Relationship and Communication Practices

Triaged Access at Emergent, Urgent and Routine Times

- PCPs and behavioral health service providers have established a reliable positive working relationship and regular communication exchange among one another.

Smooth Hand-off

- PCPs routinely discuss patient care issues with behavioral health service providers prior to and after same-day hand-offs or prior to a scheduled initial visit.

Sharing Expertise

- PCPs are comfortable routinely requesting advice from Behavioral Health Providers about intervening with patients who present with behavioral health and medical concerns.

Training Activities

- Behavioral health service providers provide periodic training and education for medical staff on behavioral health topics (e.g., at a provider meeting, through a monthly newsletter or a lunch time training on a topic of interest to PCPs).

Program Leadership

- PCPs have a defined steering group and medical champion for the practice's behavioral health integration activities.

II. Patient Care and Population Impact

Routine Screening and Referral for Adult Behavioral Health Issues

- Patients are routinely screened prior to or during annual physical exams with a standardized tool for both depression and alcohol use.

Behavioral Health Skills Used by the Care Team

- PCP staff providing direct service are trained in patient activation and health behavior change techniques.
- PCPs and (other members of the care team as appropriate) deliver evidence-based interventions in consultation with behavioral health service providers.

III. Requirements to Ensure Effective Community Integration

Self-Help Referral Connections

- PCP practices have available and regularly use referral information for self-help groups, and offers books, pamphlets and websites that foster patient self-help

Community Group and Resources Connections

- PCPs provide linkages that facilitate the connection of patients with community resources such as gyms, churches, housing and food support.

Specialty Mental Health and Substance Abuse Referral Connections

- PCPs establish and use referral and information-sharing protocols with an array of mental health and substance abuse specialty services.

IV. Care Managers

Coordination of an Integrated Treatment Plan

- Integrated treatment plans (plans that include medical and behavioral health goals) are effectively coordinated by the Clinical Care Manager.

Use of Behavioral Health Skills

- Behavioral health skills are used by the Clinical Care Manager when working with patients.

Use of Community Resources

- The Clinical Care Manager is aware of behavioral health-focused community resources and regularly utilizes them.

V. Clinic System Integration

Schedule Accessibility

- The PCP can facilitate the scheduling of a behavioral health visit for a patient at the time of a patient visit.

Leaders are committed to integrated care

- PCP staff leadership understands the value of the behavioral health service to patients and will commit to maintaining effective BH integration.

Staffing or Affiliations

- PCPs have sufficient Behavioral Health Provider staffing and / or referral opportunities for/ relationships with other BH services outside of the practice.

Chart Note Integration

- The behavioral health service provider chart notes are placed in the same location as PCP chart notes.

Process Integration

- Within a given practice, PCPs and individual behavioral health service providers use the same screeners and outcome instruments to follow progress.

APPENDIX M - ACCEPTABLE ADMITTED ASSETS

1.	Bonds
2.	Preferred Stocks (Stocks)
3.	Common Stocks (Stocks)
4.	First Liens - Mortgage loans on real estate
5.	Other than First Liens - Mortgage loans on real estate
6.	Properties occupied by the company (less \$0 encumbrances) (real estate)
7.	Properties held for the production of income (less \$0 encumbrances) (real estate)
8.	Properties held for sale (less \$0 encumbrances) (real estate)
9.	Cash, short-term investments, and cash equivalents
10.	Contract loans (including \$0 premium notes)
11.	Other invested assets
12.	Receivables for securities
13.	Securities lending reinvested collateral assets
14.	Aggregate write-ins for invested assets
15.	Subtotal of the assets listed above

APPENDIX N -PROGRAMMATIC REPORTING REQUIREMENTS

The following are programmatic reporting requirements with submissions directly to EOHHS. Nothing in these reporting requirements supplants Medicare Part C, Medicare Part D or MMP-specific reporting requirements.

A. Immediately

1. Notify CMS and EOHHS when the Contractor has reason to considering insolvency or otherwise has reason to believe it or any subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the Contractor's board of the potential for insolvency. **(Section 2.15.B)**
2. Notify CMS and EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify its Board of the potential for insolvency. **(Section 2.15.C)**
3. Notify CMS and EOHHS upon discovery of any critical incidents (adverse incidents) reported to the Contractor. (Section 2.16)
4. Notify CMS and EOHHS upon discovery of any required Self-Disclosures. (Section 2.16)".

B. Within 3 Days

1. For serious Complaints involving medical provider errors, the Contractor must take immediate corrective action and file reports of corrections made with CMS and MassHealth. **(Section 2.7.B)**

C. At Contract Execution

1. Sign Executive Order 504 Contractor Certification Form. **(Section 5.3.V)**

D. Within 5 Days of Contract Execution

1. Submit to EOHHS the name, resume, and job description for each of the key personnel listed. **(Section 5.3.S)**

E. As of Contract Effective Date

1. Submit to EOHHS a listing of its board of directors. **(Section 2.2.D)**
2. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, EOHHS. **(Section 2.17.B)**

F. Daily

1. Inbound Co-pay Data File **(2.16.C)**
2. On the Daily Inbound Demographic Change File, including all third party liability information on the Contractor's Enrollees. **(Section 5.1.M and Section 2.16.C)**
3. Notification of Board of Hearings Appeals. **(Section 2.12.A)**

G. No later than 5 days prior to significant change

1. The Contractor must notify CMS and EOHHS in HPMS no later than 30 calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity **(Section 5.1A)**

H. Within 7 Calendar Days

1. Notify EOHHS of Serious Reportable Events and Provider Preventable Conditions. **(Section 2.7.B)**

I. Within 30 calendar days of receipt of the Insolvency Reserve calculation

1. Contractor must submit to EOHHS written documentation of its ability to satisfy EOHHS' Insolvency Reserve Requirement. **(Section 2.15.B)**

J. Weekly

1. Submit by close of business each Friday the Notification of Pregnancy file. EOHHS shall use the file to track the eligibility and enrollment of an Enrollee who the Contractor determines is pregnant. **(Section 2.9.K)**
2. Submit by close of business each Friday the Discrepancy Report per EOHHS specifications. (Section 2.16)

K. Monthly

1. Monthly ICO Provider Directory. **(Section 2.16.C)**
2. Provide Encounter Data to CMS and EOHHS on a monthly basis per CMS and EOHHS specifications. **(Section 2.17.B)**
3. Submit Monthly Enrollment and Assessment Progress Tracking Tool per EOHHS specifications. **(Section 2.16)**
4. Submit Monthly Grievance Report per EOHHS specifications. **(Section 2.11)**

L. Semi-annually

1. Report to EOHHS regarding; other insurance, cost avoidance, and recovery. **(Section 5.1.M)**
2. Provide EOHHS with cost avoidance and recovery information on accidents and trauma cases. **(Section 5.1.M)**

M. Quarterly

1. Indicate in the appropriate certification checklist that it has notified each Massachusetts acute hospital of the number of inpatient days of service provided by each hospital to Enrollees who receive inpatient hospital services under this Contract pursuant to M.G.L.c. 118G, § 11. **(Section 2.16.B)**
2. Submit quarterly financial report to EOHHS as specified by EOHHS

N. Annually

1. Submit to EOHHS a report on outstanding litigation. (Section 2.15.B)
2. Submit to EOHHS an overall organizational chart that includes senior and mid-level managers for the organization.(Section 2.2.D)
3. Submit the appropriate certification checklist on its efforts to contract with Minority Owned Business Enterprises. (Section 2.7.A)
4. Provide EOHHS an annual summary of SREs, including the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE. (Section 2.7.B)
5. Report results of quality improvement plans for providers who receive a relatively high denial rate for prospective, concurrent, or retrospective service authorization requests. (Section 2.7.C)
6. Submit summary results of such Provider profiling and related Quality Improvement activities as a component of its annual evaluation of the QM/QI program. (Section 2.7.C)
7. Submit credentialing policies and procedures to EOHHS, if amended, and shall demonstrate to EOHHS that all providers within the Contractor's Provider Network are credentialed according to such policies and procedures. (Section 2.8.C)
8. Submit to EOHHS a certification checklist that it has implemented the actions necessary to comply with this section. (Section 2.8.C)
9. Report to EOHHS the number and rate of PCP turnover separately for those PCPs who leave the Contractor's Plan voluntarily and those PCPs who are terminated by the Contractor. If the Contractor's annual PCP turnover rate exceeds 7%, the Contractor shall submit an explanation for the turnover rate to EOHHS. (Section 2.8.D)
10. Shall annually report on its use of out-of-network providers to meet Enrollee's necessary medical service needs. (Section 2.9.A)
11. Submit an annual report of Enrollees who have been enrolled in the Contractor's Plan for one year or more with no utilization. The report shall include an explanation of outreach activities to engage these Enrollees. (Section 2.9.E)
12. Review and update annually, at a minimum, the Behavioral Health Clinical Criteria and other clinical protocols that the ICO may develop and utilize in its

review and submit any modifications to EOHHS annually for review and approval. (Section 2.9.F)

13. Review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health Services authorization policies and procedures. (Section 2.9.F)
14. Shall submit a Network Providers and Enrollees survey plan to EOHHS for approval at least annually. (Section 2.13.B)
15. Present its marketing plan in person to EOHHS for review and approval. (Section 2.14.A)
16. Demonstrate required liability protection to EOHHS. (Section 2.15.B)
17. Report annually or more frequently when requested by EOHHS, on any significant deficiencies in internal controls. (Section 2.15.C)
18. Provide the Service Organization Controls Type 1 (SOC1) report annually within 30 days of when the independent auditor issues such report. (Section 2.15.C)
19. Submit on an annual basis after each annual audit a representation letter signed by the Contractor's chief financial officer certifying that its organization is in sound financial condition and that all issues have been fully disclosed. (Section 2.15.C)
20. Submit a claims processing annual report on timely payment to providers. (Section 5.1.I)
21. Submit a certification on EOHHS Network-wide compliance with the access standards. (Section 2.9.B)
22. Demonstrate to CMS and EOHHS that all providers within the Contractor's Provider/Pharmacy Network are credentialed. The protocol must also include: Enrollee Complaints and Appeals; results of quality reviews; utilization management information; and Enrollee surveys. (Section 2.7.B)
23. Submit an updated Provider Manual(s) to EOHHS and CMS. If there are no substantial changes to the Provider Manual in a given year, then the Contractor is not required to submit a copy to EOHHS but shall certify to EOHHS that there are no substantial changes. (Section 2.8.A)
24. Demonstrate that its Provider Network meets proximity access requirements. (Section 2.8.B)

25. Submit to EOHHS and CMS annually, a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. (Section 2.13.B)
26. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the EOHHS QM manager and CMT. (2.13.B)
27. Provide CMS and EOHHS with the Contractor's annual audited financial statements within 120 days of the end of the fiscal year. (Section 2.15.C)
28. For the purpose of the Interim Settlement, the Contractor will jointly provide to CMS and EOHHS requested information within 120 calendar days following the end of each of Demonstration Years 1, 2, and 3. **(Section 4.6.B)**
29. For the purpose of the Final Settlement, the Contractor will jointly provide to CMS and EOHHS requested information within 480 calendar days following the end of each of Demonstration Years 1, 2, and 3. **(Section 4.6.B)**

O. Demonstration Year 1

1. Submit to EOHHS and CMS an annual QI Work Plan in the first Demonstration year. **(Section 2.13.B.)**

P. Ad Hoc

1. Provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. **(Section 2.17.B)**
2. Submit to EOHHS any changes in its board of directors. **(Section 2.2.D)**
3. Policies and procedures regarding the management of staff retention and employee turnover shall be provided to EOHHS upon request. **(Section 2.2.D)**
4. Information collected on the MDS-HC must be sent to MassHealth via the MDS-HC application in the Commonwealth's Virtual Gateway. **(Section 2.6.A)**
5. Provide EOHHS with a copy of the annual review and any corrective action plans for First Tier, Downstream or Related Entities. **(Appendix D)**

6. Demonstrate to EOHHS, including through submission of reports as may be requested by EOHHS, use of Alternative Payment Methodologies. **(Section 2.7.A)**
7. Submit to EOHHS, upon request, such reports or information on Provider profiling activities and related Quality Improvement activities. **(Section 2.7.C)**
8. Notify EOHHS when a provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information to EOHHS as required by EOHHS or state or federal laws, rules, or regulations. **(Section 2.8.C)**
9. If necessary to ensure adequate access, the Contractor may contract with providers who have training consistent with board eligibility but are not board certified. In such circumstances, the Contractor shall submit to EOHHS for review and approval, on a case-by-case basis, documentation describing the access need that the Contractor is trying to address. **(Section 2.8.C)**.
10. For terminations of PCPs, the Contractor must also report the termination to EOHHS. **(Section 2.9.A)**
11. Have policies and procedures for conducting monthly reviews of a random sample of no fewer than 500 Enrollees to ensure that such Enrollees received the services for which Providers billed with respect to such Enrollees; and shall report the results of such review to EOHHS as requested. **(Section 2.9.D)**
12. Submit its process for medical record reviews and the results of its medical record reviews to EOHHS. **(Section 2.13.B)**
13. Submit to EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request. **(Section 2.13.G)**
14. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Enrollee Incentives. **(Section 2.13.H)**
15. Inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to EOHHS, at the direction of EOHHS, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any. **(Section 2.13.H)**
16. If a Contractor's working capital falls below zero, the Contractor must immediately notify EOHHS and submit for EOHHS approval a written plan within 30. **(Section 2.15.A)**

17. Provide EOHHS with performance guarantees. (Section 2.15.B)
18. In the manner and frequency directed by EOHHS, the Contractor shall submit reports relating to Section 1202 Provider Payments. (Section 2.15.C)
19. HIPAA-compliant exchange of Member information between the Contractor and EOHHS. (Section 2.16).
20. Submit to EOHHS all applicable MassHealth reporting requirements in compliance with 42 C.F.R. § 438.602-606; (Section 2.16.B)
21. Provide any information required on it or its first-tier, downstream or related entities. (Section 2.16.B)
22. HIPAA 834 History Request File. (Section 2.16.C)
23. Contractor's Continuity of Operations Plan (COOP) and shall be submitted to EOHHS upon request. (Section 2.16.C)
24. Any additional reports/notifications as required by the Contract or as directed by EOHHS.
25. Submit a written request, accompanied by supporting documentation, to contract management team to disenroll an Enrollee, for cause. (Section 2.3.B)
26. The Contractor shall notify EOHHS and CMS of SREs. (Section 2.7.B)
27. Providing records at the request of MassHealth or CMS, or both, for monitoring the quality of care provided by the Contractor. (Section 2.6.F)
28. Notify CMS and EOHHS, via the contract management team, when it terminates, suspends, or declines a provider from its Network because of fraud, integrity, or quality. (Section 2.8.C)
29. Submit to EOHHS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by EOHHS and CMS. Such reports shall include information regarding progress on Quality Improvement Project Requirements, barriers encountered and new knowledge gained. As directed by EOHHS and CMS, the Contractor shall present this information to EOHHS and CMS at the end of the quality improvement requirement project cycle as determined by EOHHS and CMS. (Section 2.13.C)
30. Make available to CMS and EOHHS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Eligible Beneficiaries. (Section 2.14.A)

31. Notify CMS and EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract. (Section 2.15.C)
32. Advise CMS and EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new contracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract. (Section 2.15.C)
33. The Contractor may maintain provider risk arrangements. The Contractor must disclose these arrangements to CMS and EOHHS as follows and meet the additional requirements specified below. (Section 2.15.C)
34. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. § 422.516, 42 C.F.R. § 423.514 and 42 C.F.R. § 438 et. seq.; **(Section 2.16.B)**
35. Report HEDIS, HOS, and CAHPS data, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by EOHHS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and EOHHS. **(Section 2.16.B)**
36. Provide to CMS and EOHHS, in a form and format approved by CMS and EOHHS and in accordance with the timeframes established by CMS and EOHHS, all reports, data or other information CMS and EOHHS determine are necessary for compliance with the provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance. **(Section 2.16.B)**
37. Submit to CMS and EOHHS any internal reports that the Contractor uses for internal management. **(Section 2.16.B)**
38. Report to CMS and the EOHHS uniform person-level Enrollee data, based upon a Comprehensive Assessment process that includes ICD-9 (or, as applicable ICD-10) diagnosis codes, the Minimum Data Set (MDS-HC or MDS 2.0 or 3.0), and any other data elements deemed necessary by CMS and the EOHHS; **(Section 2.16.C)**
39. Provide Encounter Data to CMS and EOHHS on a monthly basis. **(Section 2.17.B)**
40. If CMS, EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not 99% complete and 95% accurate, the Contractor shall notify CMS and EOHHS, prior to Encounter Data submission, that the data is not

complete or accurate, and provide an action plan and timeline for resolution.
(Section 2.18.B)

41. If, at any time, CMS and/or EOHHS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS or EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency **(Section 5.3.M)**
42. The Contractor must submit all information required to be disclosed to CMS and EOHHS in the manner and format specified by CMS and EOHHS (physician incentive plans). **(Section 5.1.G)**
43. The Contractor must provide such unique identifier to CMS and EOHHS for each of its PCPs in the format and time-frame established by CMS and EOHHS in consultation with the Contractor. **(Section 5.1.H)**
44. Any additional reports/notifications as required by the Contract or as directed by the CMT.