COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Managed Behavioral Health Vendor Contract

Between the

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

1 ASHBURTON PLACE

BOSTON, MA 02108

and

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

1000 WASHINGTON STREET

BOSTON, MA 02118

This Managed Behavioral Health Vendor Contract is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS," or "MassHealth") and the Massachusetts Behavioral Health Partnership (MBHP), a general partnership under BeaconHealth Options Inc., of Boston, MA, with principal offices at 1000 Washington Street, Boston, MA 02118 ("Contractor").

WHEREAS, The Massachusetts Executive Office of Health and Human Services (EOHHS) is the single state agency responsible for administering the Medicaid program and the state's Children's Health Insurance Program (CHIP) within Massachusetts (collectively, MassHealth), pursuant to M.G.L. c.118E, Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. § 1397aa et seq.), and other applicable laws and waivers; and

WHEREAS, EOHHS issued a Request for Responses For a Vendor to Provide a Comprehensive Behavioral Health Program and Management Support Services, and DMH Specialty Programs

on March 17, 2022 (the RFR); and

WHEREAS, EOHHS selected the Contractor, based on their response to the RFR submitted by the deadline for responses, to provide behavioral health services to MassHealth members, as set forth in the RFR and the Contract; and

WHEREAS, EOHHS seeks and the Contractor agrees to provide innovative, cost-effective, high-quality care management services, network management services, quality management activities and comprehensive Behavioral Health Services for certain MassHealth members, including but not limited to a Care Management Program for individual Enrollees with complex medical and/or behavioral health conditions; and

WHEREAS, EOHHS seeks and the Contractor agrees to continue and enhance recovery, resiliency, family-centered and strength-based approaches to the provision of care; and

WHEREAS, EOHHS seeks and the Contractor agrees to develop a robust medical and behavioral health system of care, that is integrated both at the system level and at the individual level in order to improve health care outcomes for MassHealth members; and

WHEREAS, EOHHS seeks to implement the Commonwealth's payment reform initiatives to promote the most efficient and effective use of resources; and

WHEREAS, EOHHS and the Contractor enter this Contract with an Operational Start Date of January 1, 2023; and

WHEREAS, the parties agree that the rates and terms stated herein are subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS);

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

TABLE OF CONTENTS

LIST OF APPENDICES

Section 1. DEFINITIONS AND ACRONYMS

Section 1.1 Definitions

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

N.B.: The word "day," whenever it appears in these documents, refers to a calendar day unless otherwise specified.

Accountable Care Organization (ACO) – a provider-led entity that contracts with MassHealth to provide a managed comprehensive set of covered services to a MassHealth member who chooses to or is assigned to received care from a Primary Care Provider (PCP) within the ACO's provider network. ACOs include Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (PCACOs).

Actuarially Sound Capitation Rates – capitation rates that, as described in 42 CFR 438.4, have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the contract; have been certified as meeting the requirements of 42 CFR 438.4 by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board; and have been approved by CMS. This includes capitation rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 CFR 457.10

Adjustment – a compromise between the Contractor and the Covered Individual reached at any time after an Adverse Action but before the BOH issues a decision on a BOH Appeal.

Administrative Component of the BH Covered Services Capitation Rate – a Per-Member (Covered Individual) Per-Day rate paid by EOHHS to the Contractor for the administration of the BH Covered Services for the applicable Rating Category according to **Section 4** and **Appendix H-1**.

Adult Community Crisis Stabilization (Adult CCS) – Adult CCS is a community-based program that serves a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides 24-hour, short-term, staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and treatment include the capacity to provide induction onto and bridging for medications for the treatment of opioid use disorder (MOUD and withdrawal management for opioid use disorders (OUD) as clinically indicated.

Adult Mobile Crisis Intervention (AMCI) (formerly known as Emergency Services Program (ESP)) – AMCI provides adult community-based Behavioral Health crisis assessment, intervention, stabilization and follow-up for up to three days. AMCI services are available

24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences), and provided via Telehealth to individuals age 21 and older when requested by the member or directed by the 24/7 BH Help Line and clinically appropriate. AMCIs operate Adult CCS programs with a preference for co-location of services. AMCI services must have capacity to accept adults voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

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

(1) the failure to provide MassHealth Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.9**;
(2) the denial or limited authorization of a requested service, including the determination that a requested service is not a MassHealth Covered Service;
(3) the reduction, suspension, or termination of a previous authorization by the Contractor for a service;
(4) the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue; 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;
(5) the failure to act within the timeframes for making authorization decisions; and
(6) the failure to act within the timeframes for reviewing an Internal Appeal and issuing a decision.

Alternative Formats – provision of Covered Individual 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 Covered Individual Information read aloud to a Covered Individual by the Contractor's customer services representative.

Alternative Lock-up Programs – Human service agencies contracted with the Commonwealth of Massachusetts Department of Children and Families to provide a temporary placement resource for the Commonwealth of Massachusetts state and local police departments in their efforts to comply with federal and state regulations regarding the placement of juveniles in their custody for either status or non-violent delinquent offenses.

AMCI Amount – the total amount paid for AMCI services provided under the Contract to Uninsured Individuals and persons covered by Medicare only.

Appeal Representative – any individual that the Contractor can document has been authorized by the Covered Individual in writing to act on the Covered Individual's behalf with respect to all aspects of a Grievance, Internal Appeal, or BOH Appeal. The Contractor must allow a Covered Individual to give a standing authorization to an Appeal Representative to act on his/her behalf

for all aspects of Grievances and Internal Appeals. Such standing authorization must be done in writing according to the Contractor's procedures, and may be revoked by the Covered Individual at any time. When a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent and appoint an Appeal Representative without the consent of a parent or guardian.

Applied Behavioral Analysis – A MassHealth service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning.

ASD-ID for MCPAP Regional Behavioral Health Team – a unit of contracted and credentialed providers responsible for specific geographic centers across the state, which are affiliated with MCPAP Teams. Each unit shall include at least one Licensed Applied Behavior Analyst.

ASD-ID for MCPAP Statewide Physician Consultation Team – a single centralized team of contracted and credentialed providers consisting of at least one full time equivalent physician specialized in treating ASD-ID (e.g., psychiatrist, neurologist).

Autism Spectrum Disorder-Intellectual Disability (ASD-ID) for MCPAP – a statewide program in the Commonwealth to assist Behavioral Health providers and medical professionals in supporting the mental and Behavioral Health of individuals up to age 26 with Autism Spectrum Disorder - Intellectual Disability (ASD-ID). Through ASD-ID for MCPAP, providers can consult with a Licensed Applied Behavior Analyst and ASD-ID-specialized prescribers. ASD-ID for MCPAP improves AMCI/YMCI and emergency department providers' competencies in behavioral assessment and intervention, parent coaching, and in making effective referrals for patients who need community-based services and provides access to pharmacological consultation on an emergency basis.

Autism Support Center – a center that provides an array of information and referral services, resources, and supports to children and young adults with autism spectrum disorder.

Barrier – something that bars access to or gets in the way of obtaining Behavioral Health Treatment. This could be stigma, discrimination, transportation, insurance, cost, language, etc**.**

Behavioral Health (BH) – the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders.

Behavioral Health Clinical Assessment – the comprehensive clinical assessment of a Covered Individual that includes a full bio-psycho-social and diagnostic evaluation that informs Behavioral Health treatment planning. It is performed when a Covered Individual begins Behavioral Health treatment and is reviewed and updated during the course of treatment.

Behavioral Health Clinical Assessments provided to Covered Individuals under the age of 21 require the use of the CANS Tool to document and communicate assessment findings.

Behavioral Health Community Partner (BHCP) – an entity qualified by EOHHS to work with PCACOs to coordinate Behavioral Healthcare for certain PCACO members.

Behavioral Health Covered Services (or BH Covered Services) – the services the Contractor is responsible for providing to Covered Individuals, as applicable and as described in **Appendix A-1**.

Behavioral Health Help Line – A statewide, multichannel entry point (telephone, text, chat, website, etc.) providing Behavioral Health information, resources, and referrals in a supportive, coordinated, and user-friendly approach, including 24/7 referral and dispatch to AMCI/YMCI for Behavioral Health crises.

Behavioral Health Network Provider (or BH Network Provider) – a provider that has contracted with the Contractor to provide Behavioral Health Covered Services under the BH Program.

Behavioral Health Program (BHP) – that portion of the Contract related to the administration, coordination, delivery and management of the BH Covered Services described in **Appendix A-1**.

Behavioral Health Supports for Justice Involved Individuals (BH-JI) – BH-JI Supports involve a range of functions that assist MassHealth Covered Individuals with justice involvement, either currently incarcerated or detained in a correctional facility, released from a correctional institution within one year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board, in navigating and successfully engaging with health care services, with an emphasis on Behavioral Health services. BH-JI Supports include in-reach and re-entry supports for individuals released from correctional facilities as well as community supports post-release. When directed by EOHHS, the community supports for managed care Covered Individuals post-release will be administered by MassHealth Plans as CSP-JI as described in **Section 2.6.D.7**.

Behavioral Health Urgent Care (BHUC) Program – the delivery of same-day or next-day appointments for diagnostic evaluation of new clients and urgent appointments for existing clients; psychopharmacology appointments and Medication Assisted Treatment (MAT) and Medication for Opioid Use Disorder (MOUD) within a timeframe defined by EOHHS; all other treatment appointments within 14 calendar days; and extended availability outside of weekday hours between 9am and 5pm, as specified by EOHHS and provided by certain Mental Health Centers (MHC) designated to provide BHUC, or other providers as directed by EOHHS.

Board of Hearings (BOH) – the Board of Hearings within the Executive Office of Health and Human Services' Office of Medicaid.

BOH Appeal – a written request to the BOH, made by a Covered Individual or Appeal Representative, to review the correctness of an Internal Appeal decision by the Contractor.

Bureau of Substance Addiction Services (BSAS) – a division of the Massachusetts Department of Public Health (DPH) that is responsible for setting substance use policy in the Commonwealth.

Calendar Year – the 12-month period beginning January 1 of each year.

Capitation Rate – The Administrative Component and Medical Component of the BH Covered Services Capitation Rate for the applicable Rating Category according to **Section 4** and **Appendix H-1**.

Care Coordination – management of care activities performed by the Contractor on behalf of a Covered Individual to improve health outcomes and may include medical, Behavioral Health, and pharmacy management and medication reconciliation among providers, agencies, and community social supports, as described in **Section 2.5**.

Care Management Program (CMP) – the administration and provision of certain clinical management and support activities to certain Enrollees and Providers, as described in **Section 2.5**.

Care Team – a group of individuals led by the care coordinator or care manager, including the Enrollee, the Primary Care Clinician (PCC), and any other medical or Behavioral Health provider, case manager from another state agency, and any family member or other individual requested as part of the team by the Covered Individual.

Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees states' Medical Assistance programs and states' Children Health Insurance Programs (CHIP) under Titles XIX and XXI of the Social Security Act and waivers thereof.

Child and Adolescent Needs and Strengths (CANS) Tool – a tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the discharge planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services. A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health Providers serving MassHealth Members under the age of 21.

CANS IT System – a web-based application designated by EOHHS into which Behavioral Health Providers serving MassHealth Members under the age of 21 will input: (1) the information gathered using the CANS Tool; and (2) the determination whether or not the assessed Member is suffering from a Serious Emotional Disturbance.

Certified Mental Health Peer Specialist (CPS) – a person who has been trained by an agency approved by the Department of Mental Health (DMH) who is a self-identified person with lived experience of a mental health disorder , recovery and wellness that can effectively share their experiences and serve as a mentor, advocate or facilitator for a member experiencing a mental health disorder.

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

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

Children in the Care and/or Custody of the Commonwealth – children who are Covered Individuals and who are in the care or protective custody of the Department of Children and Families (DCF), or in the custody of the Department of Youth Services (DYS). Children in the Care and/or Custody of the Commonwealth are eligible to receive services through the BHP without being required to enroll in the PCC Plan or a Primary Care ACO; however, any such children who are enrolled in the PCC Plan are considered Enrollees.

Chronic Homelessness – a definition established by the U.S. Department of Housing and Urban Development (HUD) of a disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for 12 months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter, or safe haven) over a three-year period where the combined occasions must total at least 12 months (occasions must be separated by a break of at least seven nights; stays in institution of fewer than 90 days do not constitute a break). To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness, or disability, including the co-occurrence of two or more of those conditions.

Claim – a Provider's bill for services, a line item of service, or all services for one Covered Individual or Uninsured Individual.

Clean Claim – a Claim that can be processed without obtaining additional information from the provider of the service or from a third party. It may include a Claim with errors originating from the Contractor's claims system. It does not include a Claim from a Provider who is under investigation for fraud or abuse or a Claim under review for Medical Necessity.

Clinical Criteria – the criteria used to determine the most clinically appropriate and necessary Level of Care, and intensity of services, to ensure the provision of Medically Necessary Behavioral Health Covered Services.

Cold-call Marketing – any unsolicited personal contact by the Contractor, its employees, Network Providers, agents or Material Subcontractors with a Member who is not enrolled in the PCC Plan or its BHP that EOHHS can reasonably interpret as influencing the Member to enroll in the PCC Plan or its BHP or either not to enroll in, or to disenroll from, a MassHealth managed care organization, accountable care organization, or the PCC Plan's BHP. Cold-call Marketing

shall not include any personal contact between a Network Provider and a Member who is a prospective, current or former patient of that Network Provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Member.

Community Behavioral Health Center (CBHC) – A comprehensive community behavioral health center offering crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youth, including infants and young children, and their families. CBHC services for adults are collectively referred to as the "adult component," and CBHC services for youth are referred to as the "youth component." CBHCs include an Adult Mobile Crisis Intervention (AMCI), Youth Mobile Crisis Intervention (YMCI), Adult Crisis Stabilization (Adult CCS) and Youth Crisis Stabilization (YCCS).

Community Partner (CP) – entities qualified by EOHHS to enter into contract with PCACOs to coordinate care for certain PCACO members as further specified by EOHHS. There are two types of CPs – Long-Term Services and Supports CPs (LTSS CPs) and Behavioral Health CPs (BH CPs).

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

Community Support Programs for Chronically Homeless Individuals (CSP-CHI) – a program subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, that the Contractor shall provide as described in **Section 2.6.D.5**.

Continuing Services – BH Covered Services that were previously authorized by the Contractor and are the subject of an Internal Appeal or 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 agreement executed between the Contractor and EOHHS pursuant to EOHHS's Request for Responses (RFR) for a Vendor to Provide a Comprehensive Behavioral Health Program and Management Support Services, and DMH Specialty Programs issued March 17, 2022, and any amendments thereto. This Managed Behavioral Health Vendor Contract incorporates by reference all attachments and appendices to the RFR relative to the programs included in this Contract, including the Contractor's response to the RFR.

Contract Year – A twelve-month period commencing January 1 and ending December 31, unless otherwise specified by EOHHS.

Contractor – the entity that executes this Contract with EOHHS.

Coverage Type – a scope of medical services, other benefits, or both, that are available to individuals who meet specific MassHealth eligibility criteria. Coverage Types for this Contract include MassHealth Standard, CommonHealth, Family Assistance, and CarePlus. See 130 CMR 450.105 for an explanation of each Coverage Type.

Covered Individual – a MassHealth Member who is eligible to receive Behavioral Health Covered Services under the Contract, including PCC Plan Enrollees, Members enrolled in a Primary Care ACO, Children in the Care and/or Custody of the Commonwealth, and children in MassHealth Standard or CommonHealth with other insurance.

Covered Individual at Risk of Homelessness – any Covered Individual who does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not designed for or ordinarily used as a regular sleeping accommodation for human beings.

Covered Individual Experiencing Homelessness – any Covered Individual who lacks a fixed, regular, and adequate nighttime residence who: (1) has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group; or (2) is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

Covered Individual Information – information about the Contractor for Covered Individuals that includes, but is not limited to, a Provider Directory that meets the requirements of **Section 2.7.G**, and a Covered Individual Handbook that meets the requirements of **Section 2.10.A.3**.

Credentialing Criteria – criteria that a Provider must meet to be qualified as a Network Provider.

Crisis Prevention/Response Plan – a plan directed by the Covered Individual, or in the case of Covered Individuals under age 18, their legal guardian, designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. The Crisis Prevention Plan provides a thorough checklist of the triggers that may lead to or escalate a psychiatric crisis and strategies that the individual and providers may use to support de-escalation. The plan also includes potential clinical presentations and a preferred disposition and treatment plan for each of these presentations as well as the Covered Individual's preferences with respect to involvement of the Covered Individual, his/her family and other supports, such as Behavioral Health providers, community social service agencies, and natural community supports. With the Covered Individual's consent,

the plan may be implemented by an AMCI or YMCI provider, CBHC, other BH Network Provider, the PCC, the staff from the CSA, or another provider. This type of plan may also be referred to as a Wellness Recovery Action Plan (WRAP) for adults with Severe and Persistent Mental Illness (SPMI), and a Risk Management Safety Plan for children with Severe Emotional Disturbance (SED) and their families.

Crisis Service Safety Initiative (also referred to as Living Room Model) – a peer-delivered alternative to traditional clinical emergency services that provides a safe space, allowing an individual experiencing a mental health crisis to access direct, mutual support with peers.

Culturally and Linguistically Appropriate Services (CLAS) – the National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. CLAS aims to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Date of Action – the effective date of an Adverse Action.

Deliverable – any tangible work product, including but not limited to, a report, a document, or other building block of an overall project, whether in hard copy or electronic form, specifically created or developed in accordance with the terms of the Contract.

Department of Children and Families (DCF) – the department within the Massachusetts Executive Office of Health and Human Services that provides social services to children and families.

Department of Developmental Services (DDS) – the department within the Massachusetts Executive Office of Health and Human Services that provides supports for individuals with intellectual and developmental disabilities.

Department of Mental Health (DMH) – the department within the Massachusetts Executive Office of Health and Human Services designated as the Commonwealth's mental health authority pursuant to M.G.L. c. 19 and M.G.L. c. 123, et seq.

Department of Youth Services (DYS) – the juvenile justice agency in Massachusetts.

Direct Costs – Contractor-incurred costs directly related to the administration of the Contract. Direct Costs include but are not limited to: clinical, administrative, technical and support staff assigned to the Contract; and related administrative expenses. Direct Costs do not include federal and state taxes except sales tax and taxes attributable to personnel.

Direct Service Reserve Account (DSRA) – an interest-bearing trust account maintained by the Contractor in a bank located in Massachusetts and approved by EOHHS in accordance with the provisions of the Contract, into which payments to the Contractor are deposited when paid by EOHHS.

Discharge Planning – the evaluation of a Covered Individual's medical and Behavioral Health care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one Level of Care to another Level of Care, including referral to appropriate services.

Dual Diagnosis – co-occurring mental health and substance use conditions.

Early Intensive Behavioral Intervention (EIBI) – a service that provides for the performance of behavioral assessments; interpretation of behavioral analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with the youth's successful functioning EIBI includes services provided by two different set credentials Licensed Applied Behavior Analyst and behavior technician/paraprofessional. It is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff.

Effective Date of Enrollment – as of 12:01 a.m. on the first day, as determined by EOHHS, on which the Contractor is responsible for providing Behavioral Health Covered Services, to an Enrollee and as reflected in the HIPAA 834 Outbound Enrollment File.

Eligible Days – depending on the context, the total number of days in a month for which Covered Individuals were eligible for Behavioral Health Covered Services, as determined by EOHHS; or the total number of days in a month for which Enrollees were eligible for the PCC Plan, as determined by EOHHS.

Eligibility Verification System (EVS) – EOHHS's computerized system for verifying MassHealth Member eligibility.

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

Emergency Services – MassHealth Covered Services that are furnished to a Covered Individual by a provider qualified to furnish such services under Title XIX of the Social Security Act, and that are needed to evaluate or stabilize a Covered Individual's Emergency Medical Condition.

Encounter – a professional contact between a patient and a provider who delivers health care services.

Engagement – in-person or telehealth encounter(s) with an Enrollee, for the purposes of completing a comprehensive health assessment, and creating and implementing an Individual Care Plan (ICP).

Engagement Rate – the number of Participants in the Care Management Program as a percent of the total number of Enrollees successfully engaged for whom the Contractor conducts outreach for the CMP.

Engagement Target – the minimum projected number of Enrollees in each Tier the Contractor is required to successfully enroll in the CMP each Contract Year.

Enrollee – a person determined eligible for MassHealth who is enrolled in the PCC Plan, either by choice or by assignment by EOHHS.

Enrollee Days – the sum of the number of days each Enrollee is enrolled in the PCC Plan.

Enrollment Broker – the EOHHS-contracted entity that provides MassHealth Members with assistance in enrollment into MassHealth Managed Care plans, including the PCC Plan and Primary Care ACOs.

EPSDT Periodicity Schedule – the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedules that appears in **Appendix W of all MassHealth provider manuals** and is developed and periodically updated by MassHealth in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts DPH and DMH, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Estimated Administrative Payment – a prospective monthly payment made by EOHHS to the Contractor for the administration of the BHP, based on an approximation of the number of Covered Individuals eligible for services under the Contract for that month multiplied by the applicable PMPM Administrative Component of the BH Capitation Rate.

Estimated Capitation Payment – a prospective monthly payment made by EOHHS to the Contractor, based on an approximation of the number of Covered Individuals eligible for services under the Contract for that month multiplied by the applicable PMPM Capitation Rate. The payment is made regardless of whether the Covered Individual receives services during the period covered by the payment.

Estimated PCC Plan Management Support Services Payment – a prospective monthly payment made by EOHHS to the Contractor, based on an approximation of the number of Enrollees in the PCC Plan multiplied by the PMPM PCC Plan Support Services Rate.

Executive Office of Health and Human Services (EOHHS) – the executive agency within Massachusetts that is the single state agency responsible for the administration of the MassHealth program (Medicaid), pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

External Quality Review Activities (EQR Activities) – activities performed by an entity with which EOHHS contracts in accordance with 42 CFR 438.350 through 42 CFR 438.370.

External Quality Review Contractor (EQR Contractor) – the entity with which EOHHS contracts to perform External Quality Review Activities.

Federal Financial Participation (FFP) – the federal share of the costs associated with states' administration of entitlement programs such as the Medicaid program.

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

Health Disparities – avoidable differences in health outcomes experienced by people with one characteristic (e.g., race, gender, sexual orientation) as compared to the socially dominant group (e.g., white, male, cis-gender, heterosexual, etc.).

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

Health Equity – means that everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, or socioeconomic status. Advancing health equity is a process of addressing limited access to economic resources, education, housing, etc. When focusing specifically on racial equity in health, advancing health equity means dismantling the systemic racism that underlies differences in the opportunity to be healthy.

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

Health Needs Assessment – a tool that identifies and quantifies an Enrollee's physical and Behavioral Health status and needs based on morbidity and mortality risk, derived from the collection and review of demographic, physical and Behavioral Health and lifestyle information.

Health Safety Net – unpaid hospital charges, as defined in M.G.L. c. 118G, for Medically Necessary services provided to: (1) patients deemed financially unable to pay, in whole or in part, for their care; (2) uninsured patients who receive Emergency care for which the costs have not been collected after reasonable efforts; or (3) patients in situations of medical hardship where major expenditures for health care have been depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid.

Homeless – individuals who lack regular, fixed, and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence that is a shelter or similar facility, or

who have no primary residence and utilize public areas for sleep, shelter, and daily living activities.

Indian Enrollee – An individual 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 – an Indian Health Care Provider or an Urban Indian Organization as defined in the American Recovery and Reinvestment Act of 2009.

Indirect Costs – costs charged to the Contractor by its parent to support administration of the Contract, including management, financial or other corporate functions provided to support operation of the program, and exclusive of Direct Costs. Indirect Costs do not include federal and state taxes except sales tax and taxes attributable to personnel.

Individual Care Plan (ICP) – the plan of care developed by a Clinical Care Manager in conjunction with an individual's Care Team, when appropriate and possible. The ICP includes: (1) the individual's detailed and comprehensive needs assessment; (2) identified short-term and long-term treatment goals; (3) a service plan to meet those goals; and (4) the creation of a defined course of action to enhance the individual's functioning and quality of life.

Integrated Care Management Program (ICMP) – an enhanced care management program for Enrollees with complex medical, mental health and/or substance use disorders.

Internal Appeal – a request by a Covered Individual or Appeal Representative made to the Contractor for review of an Adverse Action.

Level of Care – a differentiation of services depending on the setting in which care is delivered and the intensity of the services.

Marketing – any communication from the Contractor, its employees, Network Providers, agents or Material Subcontractors to a Member who is not enrolled in a PCACO, the PCC Plan or its BHP that EOHHS can reasonably interpret as influencing the Member to enroll in a PCACO, the PCC Plan or its BHP or either not to enroll in, or to disenroll from, a MassHealth managed care organization, accountable care organization, or the PCC Plan's BHP. Marketing shall not include any personal contact between a Provider and a Member who is a prospective, current or former patient of that Provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Member.

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

Massachusetts Behavioral Health Access (MABHA) System – a web-based searchable database maintained by the Contractor that contains up-to-date information on the number of

available beds or available service capacity for certain MassHealth Behavioral Health services, including psychiatric hospitals, Community-Based Acute Treatment Providers, and providers of Intensive Home and Community-Based Services.

Massachusetts Child Psychiatry Access Program (MCPAP) – consists of four psychiatric and behavioral consultation programs, two of which (ASD-ID for MCPAP and Early Childhood) are included in this Contract and further detailed in **Section 2.6.D.2**.

MassHealth – the Medicaid program of the Commonwealth of Massachusetts, administered by EOHHS pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

MassHealth CarePlus – a MassHealth Coverage Type that offers health benefits to certain individuals at least the age of 21 and under the age of 65 who qualify under EOHHS's MassHealth CarePlus eligibility criteria.

MassHealth CommonHealth – a MassHealth Coverage Type that offers health benefits to certain disabled children under age 18, and certain working or non-working disabled adults between the ages of 18 and 64.

MassHealth Covered Services – medical and Behavioral Health services or related care provided to Covered Individuals, in accordance with the lists of covered services associated with the MassHealth Coverage Type specified in 130 CMR 505.001 through 505.009.

MassHealth Family Assistance – a MassHealth Coverage Type that offers health benefits to certain eligible Members, including families and children under the age of 18.

MassHealth Managed Care – the provision of Primary Care, Behavioral Health, and other medical services through a contracted managed care organization, accountable care organization, or the PCC Plan, in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000 et seq.

MassHealth Managed Care Organization (MCO) – an entity that contracts with MassHealth to provide a managed comprehensive set of covered services to MassHealth Enrollees that select to enroll or who are assigned to an MCO.

MassHealth Member (Member) – any individual determined by EOHHS to meet the requirements of 130 CMR 505.002 or 130 CMR 505.005.

MassHealth Provider – a participating individual, facility, agency, institution, organization, or other entity that has appropriate credentials and licensure and has entered into an agreement with EOHHS for the delivery of MassHealth Covered Services to MassHealth Members.

MassHealth Standard – a MassHealth Coverage Type that offers a full range of health benefits to certain eligible Members, including families, children under age 18, pregnant women, and disabled individuals under age 65.

Material Subcontractor – any entity from which the Contractor procures, reprocures, or proposes to subcontract with, for the provision of all or part of its Administrative Services for

any program area or function that relates to the delivery, management or payment of BH Covered Services, including but not limited to claims processing, the Care Management Program and other care management activities, PCC Plan Management Support Services, and Utilization Management.

MCPAP Teams – multiple units of contracted and credentialed MCPAP Providers with each unit responsible for specific geographic centers across the state. Each unit shall include MCPAP Providers experienced in providing pediatric mental health and substance use disorder consultation.

Medicaid – see MassHealth.

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

Medically Necessary (or Medical Necessity) – a service is "Medically Necessary" if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the Member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the Member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. See, 130 CMR 450.204.

Medication for Opioid Use Disorder (MOUD) – the use of FDA approved medications for the treatment of substance use disorders; formerly known as Medication Assisted Treatment (MAT).

Medication Review and Reconciliation – the process of avoiding inadvertent inconsistencies in medication prescribing that may occur in transition of a patient from one care setting to another (e.g., at hospital admission or discharge, or in transfer from a hospital intensive care unit to a general ward) by reviewing the patient's complete medication regimen at the time of admission, transfer and discharge and comparing it with the regimen being considered for the new care setting.

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

Member Identification Number (MID) – the 10-digit identification number assigned to each MassHealth Member.

Network (or Provider Network) – the collective group of Network Providers who have entered into Provider Agreements with the Contractor for the delivery of BH Covered Services.

Non-Medical Programs and Services – an item or service which the Contractor decides to make available to its Covered Individuals, which is not a Behavioral Health Covered Service. The Contractor must use its own funds to provide such Non-Medical Programs and Services and may not include the costs of such Non-Medical Programs and Services as medical service costs or administrative costs for purposes of MassHealth rate development.

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

Operational Start Date – the date, as determined by EOHHS, on which the Contractor assumes responsibility for the administration, delivery and coordination of the functions and responsibilities described in this Contract.

Opioid Treatment Programs (OTP) – Substance Abuse and Mental Health Services Administration (SAMHSA)-certified programs, usually comprised of a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using approved medications, of individuals who are addicted to opioids in accordance with 105 CMR 164.300 and 42 CFR Part 8.

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

(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."

Outreach Target – the projected number of Enrollees the Contractor will attempt to Engage annually for Enrollment in the Care Management Program each Contract Year.

Participant – an Enrollee who is enrolled in the Care Management Program with an ICP.

Pay for Performance (P4P) – Performance Incentive Arrangement payments the Contractor may earn as described in Contract **Section 4.6**.

Payment Month – the month in which an Estimated Capitation Payment is issued to the Contractor.

PCC Panel Enrollee – an Enrollee who is assigned to the PCC Plan Provider.

PCC Plan Providers – primary care providers that serve PCC Plan Enrollees.

Peer Support – activities to support recovery and rehabilitation provided to consumers of Behavioral Health services by other individuals with personal experience with Behavioral Health conditions and services.

Per-Member (Enrollee or Covered Individual) Per-Month (PMPM) – the average monthly payment per Enrollee or Covered Individual, depending on context.

Performance Incentive Arrangement – a payment mechanism under which the Contractor may earn payments for meeting targets in the Contract. See 42 CFR 438.6(b).

Permanent Supportive Housing (PSH) – a model of housing that combines ongoing subsidized housing matched with flexible health Behavioral Health, social, and other support services.

Plan Type – an identifier used by MassHealth's MMIS to identify the Rating Category in which a Covered Individual is enrolled in the BHP.

Post-stabilization Care Services – Covered Inpatient and Outpatient Services, related to an Emergency medical condition that are provided after a Covered Individual is stabilized in order to maintain the stabilized condition, or when covered pursuant to 42 CFR 438.114(e) to improve or resolve the Covered Individual's condition.

Practice Based Care Management (PBCM) – A model of Integrated Care Management that is delivered by Primary Care Providers to improve member experience, improve care coordination and improve integration of physical and Behavioral Health care.

Practice Guidelines – systematically developed descriptive tools or standardized specifications for care to assist provider and patient decisions about appropriate health care for specific circumstances. Practice Guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

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

Primary Care – all health care services and laboratory services customarily furnished by or through a family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or nurse practitioner, to the extent the furnishing of those services is legally authorized by the Commonwealth, as further described in 130 CMR 450.101.

Primary Care Accountable Care Organization (Primary Care ACO or PCACO) – a Primary Care Case Management entity that is an advanced provider-led entity contracted with EOHHS. PCACOs contract directly with MassHealth and deliver well-coordinated care and population health management.

Primary Care Clinician (PCC) – an EOHHS-contracted Primary Care Practitioner participating in the Managed Care program pursuant to 130 CMR 450.118. PCCs provide comprehensive Primary Care and certain other medical services to PCC Plan Enrollees and function as the referral source for most other MassHealth services.

PCC Performance Dashboard – a component of the PCC Plan Management Support Services. These PCC-specific and/or PCC service location-specific reports shall contain agreed upon indicators to help PCCs and their service locations monitor their performance and to identify opportunities for quality improvement. The PCC Performance Dashboard is the provider profiling report for PCC Plan Providers.

PCC Plan – a MassHealth Managed Care option, which includes EOHHS's network of PCCs, specialty care providers and the BHP.

PCC Plan Management Support Services (PMSS) – services designed to support MassHealth in managing the PCC Plan in a cohesive fashion with a focus on quality management and operational support.

PCC Plan Management Support Materials – educational materials distributed by the Contractor to PCCs (and other providers as appropriate) to promote improvement in the delivery of health care services and in Enrollee health outcomes.

PCC Plan Support Managers – Contractor staff dedicated solely to the Contract, with appropriate network management, QM, provider relations, and relevant clinical background and experience.

PCC Provider Contract – a PCC's written agreement with EOHHS to be a PCC in the PCC Plan. The PCC may hold a contract for one or more PCC Service Locations.

PCC Service Location – the site at which an Enrollee is enrolled once an Enrollee chooses or is assigned to the PCC Plan. A PCC Service Location is denoted by a Provider Identification and Service Location (PID/SL) number which is system-generated by the EOHHS MMIS. A PCC may have one Service Location or multiple Service Locations.

Primary Care Practitioner (PCP) – a health care professional who provides Primary Care services.

Privacy Rule – the standards for privacy of individually identifiable health information required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended).

Protected Health Information (PHI) – any information in any form or medium: i) relating to the past, present or future, physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual, and ii) identifying the Individual or with respect to which there is a reasonable basis to believe can be used to identify the Individual. PHI shall have the same meaning as used in the Privacy Rule. PHI constitutes Personal Data as defined in M.G.L. c. 66A, § 1.

Provider – an individual, group, facility, agency, institution, organization, or business that furnishes or has furnished medical services to Covered Individuals.

Provider Agreement – a binding agreement between the Contractor and a BH Network Provider that includes, among other things, all of the provisions set forth in **Section 2.7.A.**

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

Quality Management (QM) – the process of reviewing, measuring and continually improving the outcomes of care delivered.

Rating Category (RC) – a specific group of Covered Individuals for which a discrete BH Covered Services Capitation Rate applies, as described in **Section 4.1**.

Recovery Coach – an individual currently in recovery who has lived experience with substance use and/or co-occurring mental health disorders and has been trained to help their peers with a similar experience to gain hope, explore recovery, and achieve life goals. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking individuals to recovery community and serving as a personal guide and mentor.

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

Restoration Center – a site that provides Behavioral Health Services to adults 18 and older, who are at risk of becoming involved with the criminal justice system due to their Behavioral Health status, and who could benefit from urgent access to Behavioral Health Services that could prevent law enforcement contact, including diverting individuals experiencing mental health or substance use disorder crises from arrest and from emergency department (ED) utilization.

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

Serious and Persistent Mental Illness (SPMI) – a mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and is the primary cause of a functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic

criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (5th ed., text revision) American Psychiatric Association, Washington, DC (2013), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders, including delirium, dementia or amnesia; or (c) mental disorders due to a general medical condition not elsewhere classified; or (d) substance-related disorders.

Serious Reportable Event (SRE) – an event that is specified as such by EOHHS.

Service Compensation Rate – a dollar amount to be paid monthly by EOHHS to the Contractor for the delivery of AMCI/YMCI services to Uninsured Individuals and persons covered by Medicare only as set forth in this Contract.

Telehealth – provision of a Behavioral Health Covered Service remotely by a physician or practitioner through the use of interactive telecommunications equipment. Also referred to as telemedicine or telepsychiatry.

Therapeutic Milieu – A setting including but not limited to a partial hospital program, psychiatric day treatment program, or CBAT, where Behavioral Health services are provided.

Third-Party Liability (TPL) – other insurance resources, such as Medicare and commercial insurance, available for services delivered to MassHealth Members.

Uninsured Individuals – those individuals who are not MassHealth eligible, and do not have insurance coverage.

Urgent Care – the delivery of same-day or next-day appointments for diagnostic evaluation of new clients and urgent appointments for existing clients; psychopharmacology appointments and Medication Assisted Treatment (MAT) and Medication for Opioid Use Disorder (MOUD) within a timeframe defined by EOHHS

Utilization Management (UM) – the process of evaluating the clinical necessity, appropriateness, and efficiency of care and services. This may include service authorizations and prospective, concurrent, and retrospective review of services and care delivered by Providers.

Virtual Gateway – an internet portal designed and maintained by EOHHS to provide the general public, medical providers, community-based organizations, MassHealth Managed Care contractors, and EOHHS staff with online access to health and human services.

Wellness Programs – programs that promote an active process to help individuals become aware of and learn to make healthy choices that lead toward a longer and more successful existence.

Youth Community Crisis Stabilization (YCCS) – staff, secure, safe, and structured crisis stabilization and treatment services in a community-based program that provides active treatment that includes restoration of functioning; strengthening the resources and capacities of the youth,

family, and other natural supports; and ensuring a timely return to previous living environment to individuals up to and including 18 years of age.

Youth Community-based Mobile Crisis Intervention (YMCI) – YMCI provides a short-term service that is a mobile, on-site, face-to-face therapeutic response to youth under the age of 21 experiencing a Behavioral Health crisis and includes follow-up for up to seven days. YMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences), and via telehealth when requested by the family and clinically appropriate. YMCIs will have access to Youth Crisis Stabilization (YCCS) services. YMCI services must have capacity to accept youth voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.

Section 1.2 Acronyms

The following acronyms are commonly used in the health care industry and/or frequently found throughout this Contract and its Appendices:

Acronym	Description
ABA	Applied Behavioral Analysis
ACA (or PPACA)	Patient Protection and Affordable Care Act of 2010
ACO	Accountable Care Organization
ACPP	Accountable Care Partnership Plan
Adult CCS	Adult Community Crisis Stabilization
ALP	Alternative Lock-up Programs
AMCI	Adult Mobile Crisis Intervention
AND	Administratively Necessary Days
ASAM	American Society for Addiction Medicine
ASC	Autism Support Center
ASD	Autism Spectrum Disorder
ASD-ID	Autism Spectrum Disorder-Intellectual Disability
BBA	Balanced Budget Act of 1997
BH	Behavioral Health
BHP	Behavioral Health Program
BH-JI	Behavioral Health-Justice Involved
BHUC	Behavioral Health Urgent Care
BOH	Board of Hearings
BORIM	Board of Registration in Medicine
CANS	Child and Adolescent Needs and Strengths
CBAT	Community Based Acute Treatment
CBHC	Community Behavioral Health Center
CBHI	Children's Behavioral Health Initiative
CFR	Code of Federal Regulations
CMP	Care Management Program
CMR	Code of Massachusetts Regulations
CMS	the federal Centers for Medicare and Medicaid Services

Acronym	Description
CPS	Certified Peer Specialist
CSA	Community Service Agency
CSP-CHI	Community Support Program for Chronically Homeless Individuals
CSP-JI	Community Support Program-Justice Involved
CY	Contract Year
D/HoH	Deaf and/or Hard of Hearing
DCF	the Massachusetts Department of Children and Families
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DDS	the Massachusetts Department of Developmental Services
DMH	the Massachusetts Department of Mental Health
DPH	the Massachusetts Department of Public Health
DPH/BSAS	Bureau of Substance Abuse Services of the Mass. Department of Public Health
DRM	Document Review Measure
DSRA	Direct Service Reserve Account
DUR	drug utilization review
DYS	the Massachusetts Department of Youth Services
ECC	Enhanced Care Coordination
ECMH	Early Childhood Mental Health
ED	emergency department
EOHHS	the Massachusetts Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	external quality review
EVS	Eligibility Verification System
FFP	Federal Financial Participation
FFS	fee-for-service
FTE	full-time equivalent
FY	fiscal year
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HEC	Health Equity Committee
HIPAA	Health Insurance Portability and Accountability Act of 1996
HNA	Health Needs Assessment
IBNR	incurred but not reported
ICC	intensive care coordination
ICM	intensive clinical management
ICMP	Integrated Care Management Program
IDD	Intellectual or Developmental Disability
IECMH	Infant Early Childhood Mental Health
LABA	Licensed Applied Behavior Analyst
LEIE	Office of the Inspector General List of Excluded Individuals Entities
MABHA	Massachusetts Behavioral Health Access
MBR	MassHealth benefit request (application) form
MCI	mobile crisis intervention

Acronym	Description
MCO	Managed Care Organization
MCPAP	Massachusetts Child Psychiatry Access Program
MFD	Medicaid Fraud Division
MGL	Massachusetts General Laws
MHC	Mental Health Center
MID	Member Identification Number
MIS	Management Information System
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MOUD	Medication for Opioid Use Disorder
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
OCA	Office of Clinical Affairs
OTP	Opioid Treatment Program
P4P	Pay For Performance
PAP	Pre-Arraignment Protocol
PBCM	Practice Based Care Management
PCC	Primary Care Clinician
PCP	Primary Care Practitioner
PD	PCC Performance Dashboard
PFR	Pay For Reporting
PHI	Protected Health Information
PID/SL	Provider Identification and Service Location
PIHP	Prepaid Inpatient Health Plan
PMPM	Per Member (Enrollee or Covered Individual) Per Month
PMSS	PCC Plan Management Support Services
POPS	Pharmacy Online Processing System
PPC	Provider Preventable Conditions
PPHSD	Preventive Pediatric Health-Care Screening and Diagnosis
PPPM	per participant (in the Care Management Program) per month
PSH	Permanent Supportive Housing
QI	quality improvement
QIP	Quality Improvement Project
QM	Quality Management
QLT	Quantitative Treatment Limitation
RC	Rating Category
RRS	Residential Rehabilitation Services (Level 3.1)
S2BI	Screening to Brief Intervention
SED	Serious Emotional Disturbance
SPMI	Serious and Persistent Mental Illness
SRE	Serious Reportable Event
TCM	Therapeutic Class Management
TPL	Third-Party Liability

Acronym	Description
UM	Utilization Management
VG	Virtual Gateway
YCCS	Youth Community Crisis Stabilization
YMCI	Youth Mobile Crisis Intervention

Section 2. CONTRACTOR RESPONSIBILITIES

Section 2.1 Compliance

A. General

1. The Contractor shall comply, to the satisfaction of EOHHS, with (1) all provisions set forth in this Contract and (2) all applicable provisions of state and federal laws, regulations, and waivers.

2. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, EOHHS may take non-compliance actions as specified in **Section 5.3.L** and **Section 5.3.M** of this Contract, which include but are not limited to, requiring the Contractor to hire additional staff and the application of sanctions.

B. Federal Managed Care Law

The contractor shall comply with applicable provisions of 42 U.S.C. § 1396u-2 et seq. and 42 CFR 438 et seq. at all times during the term of this Contract.

C. Conflict of Interest

Neither the Contractor nor any Material Subcontractor 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, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual or other business interest in EOHHS's Enrollment Broker or the External Quality Review Contractor.

D. Systems Interface

The Contractor or its designated subcontractor shall take all steps necessary, as determined by EOHHS, to ensure that the Contractor's systems are always able to interface with the Medicaid Management Information System (MMIS), the Virtual Gateway, and other EOHHS IT applications.

Section 2.2 Contract Transition/Contract Readiness

A. Contract Transition Phase

The Contractor shall comply with all requirements related to the Transition Phase of the Contract as detailed herein and in **Appendix B-1**. The Contract Transition Phase includes, but is not limited to, the period between the Contract Effective Date and the Contract Operational Start Date.

1. Transition Schedule

The Transition Phase will begin after the Contract is executed. The Transition Phase must be completed no later than the Contract Operational Start Date.

2. Transition Workplan

a. No later than five business days following the Contract Effective Date, the Contractor shall submit to EOHHS, for its review and approval, a Transition Workplan which shall be used by EOHHS to monitor the Contractor's progress toward achieving Contract Readiness, as detailed in **Section 2.2.B** below. At a minimum, the Transition Workplan must address all of the items listed in **Sections 2.2.B** and **2.2.C** below, and **Appendix B-1** unless otherwise directed by EOHHS.

b. The Transition Workplan must list each task, the date by which it will be completed, how it will be completed, and the documentation that will be provided to EOHHS as evidence that the task has been completed.

B. Contract Readiness Review

1. During the Transition Phase, EOHHS will conduct a readiness review of the Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2. The readiness review shall be conducted prior to enrollment of Covered Individuals with the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS. EOHHS will conduct the readiness review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional readiness review in the event that additional populations become managed care eligible.

3. Scope of Readiness Review

The Contractor agrees to provide all materials required to complete the readiness review by the dates established by EOHHS. The scope of the Readiness Review shall include, but may not limited to:

a. An assessment of the Contractor's ability and capability to perform, at a minimum, its obligations under the Contract satisfactorily in the following areas consistent with 42 CFR 438.66(d)(4):

1) Operational and Administration, specifically:

a) Staffing and resources, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with **Section 2.3**;

b) Delegation and oversight of Contractor responsibilities, including but not limited to capabilities of Material Subcontractors in accordance with **Section 2.2.B.6 and Appendix B-2.**;

c) Enrollee and Provider communications;

d) Internal Grievance and Appeal policies and procedures, in accordance with **Section 2.12**;

e) Enrollee services and outreach, including capabilities (materials, processes and infrastructure, e.g., call center capabilities), in accordance with **Section 2.10**;

f) Provider Network management, including Provider Network composition and access, in accordance with **Section 2.9.B through D**;

g) Program integrity and compliance, including Fraud and Abuse and other program integrity requirements in accordance with **Section 2.3.C.3**;

2) Service Delivery

a) Case management, care coordination, and service planning in accordance with **Section 2.5**;

b) Quality improvement, including comprehensiveness of quality management/quality improvement strategies, in accordance with **Section 2.13;** and

c) Utilization Review, including comprehensiveness of Utilization Management strategies, in accordance with **Section 2.6.C**

3) Financial Management

a) Financial reporting and monitoring; and

b) Financial solvency, in accordance with **Section 2.15**;

4) Systems Management

a) Claims management; and

b) Encounter Data and enrollment information, as applicable, management, including but not limited to, at the request of EOHHS, a walk-through of any information systems, including but not limited to enrollment, claims payment system performance, interfacing and reporting capabilities

and validity testing of Encounter Data, in accordance with **Section 2.14**, including IT testing and security assurances.;

b. A review of other items specified in the Contract, including but not limited to:

1) All deliverables that EOHHS has specified must be in place prior to the Contract Operational Start Date, as set forth in **Appendix B-1**;

2) Marketing materials, in accordance with **Section 2.11**;

3) Content of Provider Contracts, including any Provider Performance Incentives, in accordance with **Sections 2.7.A**; and

4) Content of Material Subcontracts with Community Partners, in accordance with **Sections 2.5.K.**

4. EOHHS will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract. The Contractor must provide EOHHS with a corrective action plan within 10 business days after being informed of any deficiency EOHHS identifies during the readiness review. EOHHS, may, in its discretion, modify or reject any such corrective action plan, in whole or in part.

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

6. The Contractor shall demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet all Contract requirements identified in the readiness review within a timeline and workplan identified by EOHHS. Requirements will need to be met between 60 and 15 business days prior to the Contract Operational Start Date. The Contractor shall provide EOHHS with a certification, in a form and format specified by EOHHS, demonstrating such readiness.

7. Covered Individuals shall not be enrolled with the Contractor unless and until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the readiness review, except as provided below.

8. EOHHS may, in its discretion, enroll Covered Individuals with the Contractor as of the Contract Operational Start Date provided the Contractor and EOHHS agree on a corrective action plan to remedy any deficiencies EOHHS identifies pursuant to this Section.

9. The readiness provisions in this Section shall also apply, as determined appropriate by EOHHS, upon the implementation of changes in scope to this Contract and new programs or initiatives as described in **Sections 5.7** of this Contract.

C. Continuity of Care for New Covered Individuals

The Contractor shall develop and implement policies and procedures to ensure continuity of care for new Covered Individuals that are enrolling with the Contractor, including from an Accountable Care Partnership Plan, an MCO or a commercial carrier. Such policies and procedures:

1. Shall be for the purpose of minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary Behavioral Health Covered Services;

2. Shall address continuity of care for all such Covered Individuals and include specific policies and procedures for the following individuals at a minimum:

   a. Covered Individuals who, at the time of their enrollment:

      1) Are pregnant;

      2) Have significant health care needs or complex medical conditions;

      3) Have autism spectrum disorder (ASD) and are currently receiving ABA Services, including through MassHealth, an Accountable Care Partnership Plan, MCO, or a commercial carrier and have a current prior authorization for ABA Services in place;

      4) Are children in the care or custody of DCF, and youth affiliated with DYS (either detained or committed) or receiving services from DDS;

      5) Are hospitalized; or

      6) Are receiving treatment for behavioral health or substance use; or

   b. Covered Individuals who have received prior authorization for Behavioral Health Covered Services, including but not limited to inpatient services.

3. Shall include, at a minimum, provisions for:

   a. Identifying and communicating with Covered Individuals for whom continuity of care is required in accordance with this Section, and those

Covered Individuals' providers (including but not limited to Network Providers);

b. Facilitating continuity of care so that new Covered Individuals may continue to see their current providers (including but not limited to Network Providers) for Medically Necessary Behavioral Health Covered Services for at least 90 days from the Operational Start Date, or otherwise 90 days after the Effective Date of Enrollment except where specified below, including but not limited to:

    1) Ensuring that Covered Individuals currently receiving inpatient care from a hospital, including non-Network hospitals, at the time of their enrollment may continue to receive such care from such hospital as long as such care is Medically Necessary. The Contractor shall make best efforts to contact such hospital to ensure such continuity of care;

    2) Ensuring that, for at least 90 days from the Operational Start Date or 90 days after the Effective Date of Enrollment, new Covered Individuals receiving outpatient Behavioral Health or substance use disorder care, including but not limited to Covered Individuals with upcoming appointments, ongoing treatments or services, or prior authorizations, may continue to seek and receive such care from providers (including non-Network) with whom they have an existing relationship for such care;

    3) Ensuring that, for at least 90 days from the Operational Start Date or 90 days after the Effective Date of Enrollment, Covered Individuals actively receiving ABA Services for autism spectrum disorder may continue to receive such services from providers (including non-Network) with whom they have an existing relationship for such care. The Contractor shall develop related protocols that include at a minimum the use of single-case agreements, full acceptance and implementation of existing prior authorizations for ABA Services, and individual transition plans.

    4) Otherwise making accommodations for:

        a) Upcoming appointments;

        b) Ongoing treatments or services;

        c) Inpatient care; and

        d) Other medically necessary services.

c. Ensuring that all such providers are able to confirm or obtain any authorization, if needed, for any such services from the Contractor;

d. Honoring all prior authorizations and prior approvals for services for the duration of such prior authorizations and prior approvals or, if the Contractor chooses to modify or terminate a prior authorization and prior approval, then the Contractor shall treat such modification or termination as an Adverse Action and follow the appeal rights policy and procedures, including notification to the Covered Individual and the Covered Individual's provider in question;

e. Ensuring appropriate medical record documentation or any continuity of care or transition plan activities as described in this Section;

f. Ensuring that all Covered Individuals, including new Covered Individuals, may access Emergency Services at any emergency room, including from out-of-Network Providers, and that such Services are provided at no cost to the Covered Individual, as described in **Section 2.9**;

g. For Covered Individuals affiliated with other state agencies, coordination and consultation with such agencies as described in **Section 2.5**;

h. Accepting and utilizing medical records, claims histories, and prior authorizations from a Covered Individual's previous Accountable Care Partnership Plan or MassHealth-contracted MCO or from MassHealth. Provisions shall also include accepting and utilizing available medical records, claims histories, and prior authorizations from a Covered Individual's previous commercial carrier to the extent such information is made available by the Covered Individual, the Covered Individual's provider, or MassHealth. The process shall require the Contractor to, at a minimum:

    1) Ensure that there is no interruption of Behavioral Health Covered Services for Covered Individuals;

    2) Accept the transfer of all medical records and care management data, as directed by EOHHS;

    3) Accept the transfer of all administrative documentation, as directed by EOHHS, including but not limited to:

        a) Provider Fraud investigations;

        b) Complaints from Covered Individuals;

        c) Grievances from Providers and Covered Individuals;

        d) Quality Management Plan; and

        e) Quality Improvement project records;

i. As directed by EOHHS, participating in any other activities determined necessary by EOHHS to ensure the continuity of care for Covered Individuals, including making best efforts to:

1) Outreach to new Covered Individuals within two business days of such new Covered Individual's Effective Date of Enrollment for a period at the start of the Contract to be specified by EOHHS and expected to last no more than 120 days from the Contract Operational Start Date. Such outreach may include telephone calls, mail, or email, as appropriate and compliant with all applicable laws;

2) Obtain any necessary consents from Covered Individuals who were formerly Covered Individuals or Covered Individuals leaving the Contractor's Plan, in order to transfer certain information specified by EOHHS to such Member's or Covered Individual's new MassHealth Accountable Care Partnership Plan or MCO Plan; and

3) As directed by EOHHS, transferring all information related to prior authorizations.

j. No later than one month prior to the Contract Operational Start Date, accepting transfer of all authorizations that are valid for dates of service after the Contract Operational Start Date; and each business day beginning 30 days prior to the Contract Operational Start Date, transferring from the previous behavioral health vendor contract information on all services that were registered the previous day and that are valid for dates of service after the Contract Operational Start Date;

k. Prior to the Contract Operational Start Date, providing written instructions to those network and non-network providers from the previous behavioral health vendor contract regarding any changes from the previous contract to the Contractor's service authorization requirements and procedures for using the service authorization system, and schedule training sessions with Network Providers to review policies and procedures for any such changes, as necessary; and

l. For any Covered Services authorized under the previous behavioral health vendor contract, adjudicating and paying claims from BH Network Providers under the previous contract for services provided on or after the Contract Operational Start Date;

4. Shall include designating a specific contact person to respond to EOHHS requests and concerns related to continuity of care. The Contractor shall provide EOHHS with such individual's name, telephone number, and email address, and shall

ensure such individual is available to EOHHS during business hours and at other times specified by EOHHS; and

5. Shall be submitted to EOHHS for approval on a date specified by EOHHS.

Section 2.3 Administration and Contract Management

A. Organization, Staffing and Key Personnel

The Contractor shall have in place organizational, operational, managerial, and administrative structures and systems capable of fulfilling all Contract requirements.

1. Organizational Performance and Quality Control

The Contractor shall:

a. Comply with Office of State Comptroller (OSC) and the Committee of Sponsoring Organization (COSO) Internal Control Standards.

b. Have in place a process for investigating and resolving any EOHHS dissatisfaction with the Contractor's performance and for improvements in its internal systems.

c. Maintain internal quality standards, indicators and written procedures to ensure accurate, timely, and consistent Contract activities to promote:

1) Adherence to Contract deadlines for the submission of accurate and timely reports and other materials;

2) Accurate and consistent dissemination of oral and written information by Contractor staff;

3) Accurate, clear documentation of the Contractor's activities (programmatic and financial) required by EOHHS;

4) Data integrity and confidentially of the Contractor's MIS, including maintenance of history files; and

5) Any other EOHHS-specified operational and reporting performance criteria.

d. Monitor internal quality control measures, standards, and procedures on a continuous basis and update them as needed to keep them current with standards.

e. Report to EOHHS in writing all internal quality control issues and findings when and if they arise.

2. Staffing Requirements

a. The Contractor shall recruit and maintain an appropriately qualified and diverse workforce, sufficient in number for the efficient execution of all Contract responsibilities.

1) The Contractor's resource allocation shall be adequate to achieve positive outcomes in all functional areas within the organization. Adequacy shall be evaluated based on outcomes and compliance with the requirements of the Contract.

2) The Contract must ensure that it properly allocates and tracks the time expended by Key Personnel and, as appropriate, other personnel among the administration of the PCC Plan's BHP, PCC Plan Management Support Services and DMH Specialty Programs administration.

b. The Contractor shall recruit and maintain an adequate number of appropriately qualified and diverse staff in order to perform Network Management activities efficiently in the communities across the Commonwealth, so that Covered Individuals and BH Network Providers, PCCs and Providers have timely access to Contractor staff in all regions of Massachusetts.

c. The Contractor must maintain a staff that reflects the cultural, linguistic and demographic characteristics of Covered Individuals, including a sufficient number of bilingual staff capable of communicating in English and Spanish, and other languages as appropriate.

d. The Contractor shall not employ or subcontract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any federal healthcare program. The Contractor shall screen all potential employees and Subcontractors to determine whether any of them have been excluded from participation in federal healthcare programs utilizing, at a minimum, the following websites:

1) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);

2) The System of Award Management (SAM); and

3) Other applicable sites as may be determined by EOHHS.

e. The Contractor shall conduct an annual criminal background check on all current or potential employees or Subcontractors who have access to Covered Individual protected health information. The Contractor shall, upon request, provide EOHHS with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has

been completed for any of its staff or Subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

f. The Contractor shall provide a copy of the Contractor's organizational chart with reporting structures, names, and positions to EOHHS annually and upon request. The organizational chart shall show the ongoing leadership and program support that will be provided to the Contractor by the Contractor's parent organization, if any.

g. The Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law.

3. Key Personnel

a. The Contractor shall employ the following or similarly titled or functional full-time personnel designated as key personnel under the Contract, employed in the key personnel position only upon review and approval by EOHHS. All Key Personnel shall be located in Massachusetts:

Executive Positions:

1) **Chief Executive Officer (CEO):** An individual who provides overall direction for the Contractor, is responsible for the Contract in its entirety, and who ensures that there is coordination and integration, as appropriate, of functions across the activities related to BH services, administrative services related to the PCC Plan, the full range of Care Management activities, and Specialty Services managed by the Contractor;

2) **Chief Financial Officer:** A professional who shall be responsible for seeing all financial provisions and requirements of this Contract, including but not limited to:

a) Serving as the Contractor's liaison to EOHHS's financial representatives on all financial matters, including payments, reconciliations, and financial forecasting; and

b) Validating the accuracy and completeness of all financial reports required under this Contract under the penalty of perjury;

3) **Chief Operating Officer:** A professional designated to oversee day-to-day business activities conducted pursuant to this Contract;

4) **Chief Information Officer:** A professional who oversees information technology and systems to support the Contractor's operations, including submission of accurate and timely Covered Individual encounter data;

5) **Chief Medical Officer:** A physician who shall be board-certified in psychiatry and/or internal medicine, be in compliance with all professional licensing requirements, and have at least two years of experience in managed BH care, peer review, or both;

6) **Associate Medical Directors:** Three full-time equivalent physicians who meet the following criteria:

   a) One shall be board-certified or board-eligible in child and adolescent psychiatry.

   b) One shall be board-eligible in internal medicine, with experience in integration of care across medical and Behavioral Health Providers and shall be responsible for the oversight of the Care Management Program described in **Section 2.5**.

   c) One shall be responsible for the oversight of the Quality Management program described in **Section 2.13**.

   d) If the full-time Chief Medical Officer is not a board-certified adult psychiatrist, then an additional full-time equivalent Associate Medical Director must be a board-certified adult psychiatrist.

7) **Health Equity Director:** A full-time employee who chairs the Health Equity Committee and provides leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed; and is the primary liaison between the Contractor, EOHHS, and other MassHealth plans regarding efforts to achieve Health Equity.

8) **Behavioral Health Plan Network Management Director:** An individual dedicated to the Contract, who is responsible for all BHP Network Management activities, as described in **Section 2.8**.

9) **Contract Officer:** A full-time designated individual dedicated solely to the Contract and who shall act as the liaison between the Contractor and EOHHS. The Contract Officer shall hold an executive-level key personnel position in the Contractor's organization, except that the Contractor may propose for EOHHS's prior review and approval an alternate structure for the Contract Officer position; and

Administrative Positions:

10) **PCC Plan Management Support Services Director:** An individual dedicated to the Contract, who is responsible for all

applicable PCC Plan Management Support Services activities as described in **Section 2.19**;

11) **PCC Plan Support Managers:** At least two full-time individuals dedicated solely to the Contract, with appropriate provider relations, quality management and relevant background and experience, who are responsible for conducting activities on behalf of EOHHS as described in **Section 2.19**.

12) **Quality Management Director:** A senior manager, dedicated solely to the Contract and with demonstrated expertise in quality improvement processes, who is responsible for overseeing all quality management activities related to the Contract, including but not limited to staff training for the successful performance and execution of such activities. The Quality Management Director will be accountable to the Contractor's appropriate clinical leadership, such as the Associate Medical Director for Quality Management.

13) **PCACO Support Manager:** An individual who is responsible for ensuring collaboration with all PCACOs to ensure coordination of care delivery for Covered Individuals.

14) **Youth State Agency Support Manager:** An individual who is responsible for oversight of the Contractor's activities to support youth in the care and custody of the Commonwealth or youth involved with state agencies.

15) **Ombudsman Liaison:** An individual who shall liaise with EOHHS' Ombudsman to resolve issues raised by Covered Individuals.

b. The Contractor's designated Contract Officer shall be authorized and empowered to represent the Contractor in all matters pertaining to the Contract and shall have responsibility for:

1) Ensuring the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2) Overseeing the Contractor's implementation of all EOHHS-approved plans, policies and timelines;

3) Overseeing all Contract-related activities by the Contractor, each Material Subcontractor and all other subcontractors, including coordinating with the Contractor's key personnel as described in **Section 2.3.A**;

4) Receiving and responding to all inquiries and requests made by EOHHS related to the Contract, in the time frames and formats specified by EOHHS;

5) Meeting with EOHHS's Contract Manager(s) on a routine basis as agreed upon by the parties, to discuss issues of mutual interest or concern;

6) Coordinating requests and activities among the Contractor, all subcontractors, and MassHealth and other state agency staff (including but not limited to DMH, DPH, BSAS, DCF and DYS);

7) Working to promptly resolve any Contract-related issues identified by the Contractor or EOHHS; and

8) Tracking the compliance of all Contract requirements and deliverables and maintaining records of all compliance activities and compliance dates using an electronic software tool or other similar mechanism such as a spreadsheet. Tracking of Contract compliance shall be in a format that can be shared with EOHHS upon request or an agreed-upon reporting schedule. All deliverables, reports, contracts, subcontracts, agreements and any other documents subject to EOHHS approval shall be provided to EOHHS in accordance with Contract requirements.

c. Key executive positions cannot be vacant for more than 90 calendar days. The Contractor must notify EOHHS within 5 business days of learning that any key position is vacant or anticipated to be vacant.

d. Prior to diverting any of the specified key personnel for any reason, the Contractor must notify EOHHS in writing, and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of BH Covered Services and performance of core functions under this Contract. These changes are to be reported to EOHHS when individuals either leave or are added to these key positions.

4. Staff Training and Licensure

a. The Contractor shall ensure that all staff members, including Subcontractors, have met any applicable state or federal licensure requirements and have received appropriate training, education, experience, and orientation to fulfill the requirements of their position. EOHHS may require additional staffing if the Contractor substantially fails to maintain compliance with any provision of the Contract.

b. The Contractor shall provide initial and ongoing staff training that includes an overview of contractual, state, and federal requirements

specific to individual job functions. The Contractor shall ensure that all staff members having contact with Covered Individuals or Providers receive initial and ongoing training on health equity and social determinants of health, and with regard to the appropriate identification and handling of quality of care concerns.

c. The Contractor shall educate all staff members about its policies and procedures on advance directives.

d. The Contractor shall educate all staff members about Health Equity and related topics in accordance with **Section 2.20**.

5. Physical Presence in Massachusetts

The Contractor shall not be located outside of the United States and no operations, including that of a Material Subcontractor, may be conducted outside of the United States without prior written consent of EOHHS. The Contractor shall have an Administrative Office located in the Boston, Massachusetts metropolitan area.

B. Advisory Committees and Councils

The Contractor shall establish the advisory committees and councils for the exchange of stakeholder ideas related to this Contract, discussion of relevant topics, and the solicitation of advice, recommendations or concerns. The structure and purpose of the committees and councils must be consistent with NCQA protocols. The goal of these committees and councils shall be to foster improved quality, integrated care and Covered Individual, Provider and PCC satisfaction. The committees and councils shall follow standard rules of order and maintain a written record or minutes of each meeting. All committees and councils must meet at least once during the first six months of Contract Year One, and on a regular schedule thereafter. The committees and councils described in this Section shall not be the only venue for the Contractor to solicit input from stakeholders.

1. BH Clinical Advisory Committee

The Contractor shall establish and facilitate a BH Clinical Advisory Committee whose main objective is to support and promote improvement in the quality of BH Covered Services provided to Covered Individuals, including the integration of medical and Behavioral Health services to the benefit of the Covered Individual. The BH Clinical Advisory meetings shall be held at least three times a year and shall include refreshments (food and non-alcoholic beverages) as part of the event.

a. The membership of the BH Clinical Advisory Committee shall be subject to EOHHS's approval, and shall consist of:

1) from eight to 14 Network Providers who represent different types of Network Providers (e.g., mental health clinics, hospitals,

individual practitioners) and different BH specialties from diverse geographic areas of the Commonwealth;

2) at least one PCC; and,

3) at least one PCACO.

b. EOHHS may recommend to the Contractor Network Providers to be invited to serve on the committee.

c. EOHHS, DMH, DPH's Bureau of Substance Addiction Services (BSAS) and other state agencies and major stakeholders identified by EOHHS shall be invited to participate in the committee's meetings.

d. The activities of the BH Clinical Advisory Committee shall include:

1) establishing bylaws that include designating a term of duty for committee members;

2) meeting jointly with the PCC Clinical Advisory Committee (see **Section 2.3.B.1**, above), at least one time per Contract Year; and

3) developing agendas that promote and support the QM activities of the BHP, including the integration of medical and Behavioral Health care services to the benefit of Covered Individuals and Enrollees.

2. PCC Clinical Advisory Committee

The Contractor shall establish and facilitate a PCC Clinical Advisory Committee whose main objective is to support and promote improvement in the quality of clinical services provided to Enrollees. The meetings shall be held at least three times a year and shall include refreshments (food and non-alcoholic beverages) as part of the event.

a. The membership of the PCC Clinical Advisory Committee shall be subject to EOHHS's approval, and shall consist of:

1) from eight to 14 PCCs who represent different types of PCC practices, different PCC specialty types, and diverse geographic areas of the Commonwealth;

2) at least one BH Network Provider; and

3) other MassHealth providers acting as specialists, if directed or approved by EOHHS.

b. The activities of the PCC Clinical Advisory Committees shall include:

1) Meeting at a minimum three times in the Contract Year, with one of the meeting being a joint meeting with the BH Clinical Advisory Committee (see **Section 2.3.B.1.b.2**, below);

2) Developing agendas with the PCC Plan Director and Medical Director and that promote and support the improvement in quality of clinical services provided to Enrollees including topics pertinent to provider practice and care quality;

3) Engage speakers that present on salient topics in collaboration with the PCC Plan; and

4) Report on minutes to the meeting and provide follow-up on action items established.

3. Consumer and Family Advisory Councils

The Contractor must include Covered Individuals and their families in QM activities and document their participation in Covered Individual and family advisory councils.

4. Other Advisory Committees

As directed by EOHHS during the term of the Contract, the Contractor shall facilitate and convene additional advisory committees, which EOHHS shall chair.

C. Contract Management and Responsiveness to EOHHS

1. Performance Reviews

a. The Contractor shall attend regular performance review meetings held by EOHHS, virtually, at EOHHS' offices, or at another location determined by EOHHS, each month or more frequently at EOHHS' discretion;

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

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

1) Costs of care and utilization for Covered Individuals by types of service;

2) Performance reporting information;

3) Quality measure performance and variation and trends in such performance measures, including progress in reducing health disparities;

4) Opportunities the Contractor identifies to improve performance and plans to improve such performance, including plans proposed to be implemented by the Contractor for Network Providers;

5) Changes in Contractor's staffing and organizational development;

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

7) Any other measures deemed relevant by Contractor or requested by EOHHS.

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

2. Timely Response to EOHHS Requests

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

1) Records from Contractor's Health Information System, claims processing system, Encounter Data submission process, or other sources, to assist Contractor and EOHHS in identifying and resolving issues and inconsistencies in Contractor's data submissions to EOHHS;

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

3) Financial and data analytics, such as the Contractor's payment rates to Network Providers as a percent of MassHealth's fee schedules;

4) Documentation and information related to Contractor's care delivery, Care Management, or Community Partners responsibilities, to assist EOHHS with understanding Contractor's activities pursuant to these requirements;

5) Information about Contractor's member protections activities, such as Grievances and Appeals;

6) Documentation and information related to Contractor's Program Integrity activities as described in **Section 2.3.D.3;**

7) Documentation, analysis, and detail on the metrics evaluated in the Contractor's Quality Improvement performance and programming; and

8) Cooperation and coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor in any Fraud detection and control activities, or other activities as requested by EOHHS.

b. If the Contractor fails to satisfactorily respond within the time requested by EOHHS without prior approval from EOHHS for a late response, EOHHS may take corrective action or impose sanctions in accordance with this Contract.

D. Other Contract Management Requirements

1. Policies and Procedures for Core Functions

The Contractor shall develop, maintain, and provide to EOHHS upon request policies and procedures for all core functions necessary to effectively and efficiently meet the requirements outlined in this Contract. All policies and procedures requiring EOHHS approval shall be documented and shall include the dates of approval by EOHHS. These policies and procedures shall include, but are not limited to, the following:

a. Response to violations of Covered Individuals' privacy rights by staff, Providers, or Subcontractors;

b. Non-discrimination of Covered Individuals;

c. Non-restriction of Providers advising or advocating on a Covered Individual's behalf;

d. Appeal rights for certain minors who under the law may consent to medical procedures without parental consent;

e. Covered Individual's cooperation with those providing health care services;

f. Marketing activities that apply to the BH Contractor, Providers, and Subcontractors, as well as Contractor's procedures for monitoring these activities;

g. Cost-sharing by Covered Individuals;

h. Advance directives;

i. Assisting Covered Individuals in understanding their benefits and how to access them;

j. Access and availability standards;

k. Covered Individual's right to be free from restraint or seclusion used as a means of coercion or retaliation;

l. The provision of Culturally and Linguistically Appropriate Services;

m. Practice guidelines in quality measurement and improvement activities;

n. Compliance with Emergency Services and Post-stabilization Care Services requirements as identified in 42 C.F.R. 438.114(b);

o. Procedures for tracking Appeals when Covered Individuals become aware of the Adverse Action, in the event that no notice had been sent;

p. Handling of Complaints/Grievances;

q. Process used to monitor Subcontractor performance;

r. Claims processing;

s. Engagement and coordination with PCACOs, BH CPs, and other state agencies; and

t. Retention of medical records.

2. Material Subcontracts/Subcontractors

a. Prior to contracting with a Material Subcontractor, the Contractor shall evaluate the prospective Material Subcontractor's ability to perform the activities to be subcontracted.

b. All Material Subcontracts must be prior approved by EOHHS. To obtain such approval, the Contractor shall make a request in writing and submit with that request a completed Material Subcontractor checklist using the template provided by EOHHS and attached hereto as **Appendix B-2**, as may be modified by EOHHS from time-to-time, at least 60 days prior to the date the Contractor expects to execute the Material Subcontract. Among other things required in the checklist, the Contractor must describe the process for selecting the Material Subcontractor, including the selection criteria used.

c. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the checklist.

d. The Material Subcontract shall:

1) Be a written agreement;

2) Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the Material Subcontractor is obligated to provide;

3) Provide for imposing sanctions, including contract termination, if the Material Subcontractor's performance is inadequate;

4) Require the Material Subcontractor to comply with all applicable Medicaid laws, regulations, and applicable subregulatory guidance; and

5) Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the Material Subcontract requires the Material Subcontractor to agree as follows.

a) The State, CMS, HHS Inspector General, the Comptroller General, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Contract. This right exists through 10 years from the final date of the Contract or from the date of completion of any audit, whichever is later; provided, however that if any of the entities above determine that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time; and

b) The Material Subcontractor will make its premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above;

e. The Contractor shall monitor any Material Subcontractor's performance on an ongoing basis and perform a formal review annually. If any deficiencies or areas for improvement are identified, the Contractor shall require the Material Subcontractor 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.

f. Upon notifying any Material Subcontractor, or being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall notify EOHHS in writing no later than the same day as such notification, and shall otherwise support any necessary member

transition or related activities as described in **Section 2.2** and elsewhere in this Contract.

g. In accordance with **Appendix E-1**, the Contractor shall submit to EOHHS an annual list of all Material Subcontractors. Such annual report shall include notification if any of its Material Subcontractors are a business enterprise (for-profit) or nonprofit organization certified by the Commonwealth's Supplier Diversity Office.

h. The Contractor shall submit ad hoc reports, as frequently as necessary or as directed by EOHHS, with any changes to the above-mentioned list and report.

i. The Contractor shall make best efforts to ensure that all Material Subcontracts stipulate that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the Material Subcontractor is based.

j. Notwithstanding any relationship the Contractor may have with a subcontractor, including Material subcontractors, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract.

k. The Contractor shall remain fully responsible for meeting all of the terms and requirements (including all applicable state and federal regulations) of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

3. Program Integrity

a. General Provisions

The Contractor shall:

1) Comply with all applicable federal and state program integrity laws and regulations regarding fraud, waste and abuse, including but not limited to, the Social Security Act and 42 CFR Parts 438, 455, and 456;

2) Have adequate Massachusetts-based staffing and resources to assist the Contractor in preventing and detecting potential fraud, waste and abuse. Staff conducting program integrity activities for the Contractor shall be familiar with MassHealth and state and federal regulations on fraud, waste and abuse;

3) Provide employees, subcontractors, and agents detailed information about the False Claims Act and other federal and state

laws described in Section 1902(a)(68) of the Social Security Act, including whistleblower protections;

4) The Contractor shall have written internal controls and policies and procedures in place that are designed to prevent, detect, reduce, investigate, correct and report known or suspected fraud, waste and abuse activities;

5) In accordance with Section 6032 of the federal Deficit Reduction Act of 2005, make available written fraud and abuse policies to all employees. If the Contractor has an employee handbook, the Contractor shall include specific information about Section 6032, the Contractor's policies, and the rights of employees to be protected as whistleblowers;

6) In accordance with Mass. Gen. Laws. Ch. 12, Section 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution;

7) Meet with EOHHS at least quarterly to discuss fraud, waste and abuse, audits, and overpayment issues; and

8) At EOHHS' discretion, implement certain program integrity requirements for providers, as specified by EOHHS, including but not limited to implementing National Correct Coding Initiative edits or other CMS claims processing/provider reimbursement manuals.

b. Compliance Plan

In accordance with 42 CFR 438.608, the Contractor shall have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against Fraud, Waste and Abuse. At a minimum, the compliance plan must include the following:

1) Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state laws regarding fraud, waste and abuse;

2) The designation of a compliance officer and a compliance committee, as described in 42 CFR 438.608, that is accountable to senior management;

3) A system for training and education for the Contractor's employees, including but not limited to the Contractor's compliance officer and senior management regarding applicable

federal and state law and regulations, and the requirements under this Contract;

4) Effective lines of communication between the compliance officer and the Contractor's employees, as well as between the compliance officer and EOHHS;

5) Enforcement of standards through well-publicized disciplinary guidelines;

6) Provision for internal monitoring and auditing as described in 42 CFR 438.608;

7) Provision for prompt response to detected offenses, and for development of corrective action initiatives, as well as the reporting of said offenses and corrective actions to EOHHS as stated in this Contract and as further directed by EOHHS; and

8) Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this Section.

c. Anti-Fraud, Waste, and Abuse Plan

The Contractor must have an Anti-Fraud, Waste, and Abuse Plan to detect and prevent fraud and abuse by Network Providers and Covered Individuals that, at a minimum, addresses the following elements:

1) Reporting of suspected and confirmed fraud, waste, and abuse as required by this Contract;

2) A risk assessment of the Contractor's various fraud, waste, and abuse and program integrity processes, a listing of the Contractor's top three vulnerable areas, and an outline of action plans in mitigating such risks. The Contractor shall submit to EOHHS this risk assessment quarterly at EOHHS' request and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment and fines). With such submission, the Contractor shall provide details of such action; outline activities for employee education of federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, abuse, and waste, to ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's Compliance Plan and Anti-Fraud, Abuse, and Waste Plan;

3) Activities for Provider education of federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, waste, and abuse, specifically related to

identifying and educating targeted Providers with patterns of incorrect billing practices or overpayments;

4) Procedures designed to prevent and detect fraud, waste, and abuse in the administration and delivery of services under this Contract; and

5) Specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

a) A list of automated pre-payment claims edits;

b) A list of automated post-payment claims edits;

c) A description of desk audits performed on postprocessing review of claims;

d) A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

e) A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

f) A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials;

d. Fraud, Waste and Abuse Reporting Requirements

The Contractor shall:

1) Report no later than five business days to EOHHS all overpayments identified and recovered, specifying those overpayments due to potential fraud;

2) Report promptly to EOHHS when it receives information about a Covered Individual's circumstances that may affect their MassHealth eligibility, including but not limited to a change in the Covered Individual's residence and the death of the Covered Individual;

3) Report no later than five business days to EOHHS when it receives information about a Provider's circumstances that may affect its ability to participate in the Contractor's network or in MassHealth, including but not limited to the termination of the Provider's contract with the Contractor;

4) Verify through sampling, whether services that were represented to be delivered by Providers were received by Covered Individuals;

5) Report within five business days to EOHHS any potential Fraud, Abuse, or waste that the Contractor identifies or, in accordance with EOHHS policies, directly to the Medicaid Fraud Unit;

6) Upon a complaint of Fraud, Waste or Abuse from any source or upon identifying any questionable practices, report the matter in writing to EOHHS within five business days;

7) Submit on a quarterly basis a fraud and abuse report according to a format specified by EOHHS, and submit ad hoc reports as needed, or as requested by EOHHS in accordance with **Appendix E-1**;

8) Have the CEO or CFO certify in writing on an annual basis to EOHHS, using the appropriate **Appendix E-3** certification, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with this Contract and has not been made aware of any instances of Fraud and Abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS;

9) Notify EOHHS within two business days after contact by the Medicaid Fraud Division (MFD), the Bureau of Special Investigations (BSI) or any other investigative authorities conducting Fraud and Abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS. The Contractor, and where applicable any subcontractors or Material Subcontractors, shall cooperate fully with the MFD, BSI and other agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding; and

10) Notify EOHHS within one business day of any voluntary Provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity.

e. Handling of Provider Fraud, Waste and Abuse

The Contractor shall:

1) First notify EOHHS and receive its approval prior to initiating contact with a Provider suspected of Fraud about the suspected activity;

2) Require Providers to implement timely corrective actions approved by EOHHS or terminate Provider Contracts, as appropriate; and

3) Suspend, in accordance with all other Contract requirements and EOHHS policies, payments to Providers for which EOHHS determines there is a credible allegation of fraud pursuant to 42 CFR 455.23;

f. Recovery of Payments

1) The Contractor shall make diligent efforts to recover improper payments or funds misspent due to fraudulent, wasteful or abusive actions by the Contractor, or its parent organization, its Providers or its subcontractors.

2) The Contractor shall maintain and require its Providers to use a mechanism for the Provider to report when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment.

3) If the Contractor identifies an overpayment prior to EOHHS:

a) The Contractor shall recover the overpayment and may retain any overpayments collected.

b) The Contractor shall report the date of identification and collection, if any, quarterly on the Fraud and Abuse report.

c) In the event no action toward collection of overpayments is taken by the Contractor one hundred and eighty (180) days after identification, EOHHS may begin collection activity and shall retain any overpayments collected.

4) If EOHHS identifies an overpayment prior to the Contractor EOHHS may explore options up to and including recovering the overpayment from the Contractor.

4. Continuity of Operations Plan

The Contractor shall maintain a continuity of operations plan that addresses how the Contractor's, Material Subcontractors', and other subcontractors' operations shall be maintained in the event of a natural disaster, terrorist attack, pandemic or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. The Contractor shall provide copies of such plan

with EOHHS upon request and shall inform EOHHS whenever such plan shall be implemented.

Section 2.4 Enrollment and Education Activities

A. Eligibility Verification

The Contractor shall instruct and assist the Contractor's Providers in the process and need for verifying a Covered Individual's MassHealth eligibility and enrollment prior to providing any service at each point of service, through the use of a platform or portal maintained by the Contractor that utilizes real time EOHHS eligibility data (e.g., 834 files); provided, however, the Contractor and its Providers shall not require such verification prior to providing Emergency Services.

B. Enrollment and Disenrollment

The Contractor shall:

1. Accept for enrollment all Members identified by EOHHS in the order in which they are referred without restriction;

2. Accept for enrollment all Members identified by EOHHS at any time without regard to income status, physical or mental condition (such as cognitive, intellectual, mobility, psychiatric, and sensory disabilities as further defined by EOHHS), age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, status as a Member, pre-existing conditions, expected health status, or need for health care services;

3. Not request the disenrollment of any Covered Individual due to an adverse change in the Covered Individual's health status or because of the Covered Individual's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Covered Individual's special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation, to EOHHS to disenroll a Covered Individual, for cause, for the following reason:

    a. After reasonable efforts, the Contractor has attempted to provide Medically Necessary BH Covered Services to the particular Covered Individual through at least three Network Providers that:

        1) Meet the access requirements specified in **Section 2.9.B** for the relevant provider type; and

        2) Are critical for providing ongoing or acute BH Covered Services to meet the Covered Individual's needs;

    b. Where reasonable efforts include attempting to provide all resources routinely used by the Contractor to meet Covered Individuals' needs,

including but not limited to, Behavioral Health Services and Care Management; and

c. Despite such efforts, the continued enrollment of the Covered Individual with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Covered Individual or other Covered Individuals.

4. EOHHS reserves the right, at its sole discretion, to determine when and if the Contractor's request to terminate the enrollment of a Covered Individual will be granted based on the criteria in **Section 2.4.B.3** above. In addition, if EOHHS determines that the Contractor too frequently requests termination of enrollment for Covered Individuals, EOHHS reserves the right to deny such requests and require the Contractor to initiate corrective action to improve the Contractor's ability to serve such Covered Individuals.

C. Enrollee Outreach, Orientation, and Education

The Contractor shall:

1. For each new Enrollee who enrolls in the PCC Plan after the Contract Operational Start Date, but who has not been enrolled in the PCC Plan in the past six months, offer and make best efforts to provide to the Enrollee an orientation, by telephone or in person, within 30 days of the Enrollee's Effective Date of Enrollment in the PCC Plan. The Contractor shall submit to EOHHS for review and approval its orientation and outreach materials and phone scripts. Such orientation shall include, at a minimum:

   a. How the PCC Plan operates, including the role of the PCC;

   b. A description of MassHealth Covered Services and service limitations;

   c. Information on participating PCC Plan Providers and how to access the provider directory either via the internet or in writing;

   d. The value of screening and preventive care;

   e. How to obtain MassHealth Covered Services; and

   f. Information about the availability of and access to Ombudsman's services.

2. The Contractor shall also provide the orientation described in **Section 2.4.C.1** above to parents or guardians of newborns that are enrolled in the PCC Plan, to the extent applicable. As part of such orientation, the Contractor shall confirm the selection or assignment to a pediatrician within the newborn's geographic area as an appropriate PCC.

3. The Contractor must provide a range of health promotion and Wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall:

   a. Work with EOHHS to implement innovative Enrollee education strategies for Wellness care and immunizations, as well as general health promotion;

   b. Work with PCCs and specialists, as appropriate, to integrate health education, Wellness and prevention training into the care of each Enrollee;

   c. Participate in any EOHHS-led joint planning activities with MassHealth-contracted MCOs and ACOs to develop and implement statewide or regional approaches to Covered Individual health and Wellness education;

   d. Provide condition- and disease-specific information and educational materials to Covered Individuals, including information on its Care Management Program described in **Section 2.5**; and

   e. Provide condition- and disease-specific information and educational materials to Enrollees.

4. Ensure, in accordance with 42 U.S.C. § 1396u-2(a)(5), that all written information for use by Enrollees and potential Enrollees is prepared in a format and manner that is easily readable, comprehensible to its intended audience, well designed, and includes a card or other notice instructing the Enrollee in multiple languages that the information affects their health benefit, and to contact EOHHS for assistance with translation.

5. Make best efforts to obtain updated contact information whenever the Contractor has been unable to contact an Enrollee as a result of undeliverable mail or an incorrect telephone number. On a monthly basis, notify EOHHS of all Enrollees whom the Contractor has been unable to contact. Such notification shall be in the format and process specified by EOHHS in consultation with the Contractor.

Section 2.5 Care Management, Care Coordination and Supporting Dispositions from the ED

A. The Contractor is responsible for providing care management or care coordination support for Covered Individuals as follows:

1. The Contractor shall operate a Care Management Program for PCC Plan Enrollees as set forth in this Section, consistent with **Section 2.19**, and as further specified by EOHHS, to serve Enrollees with complex medical, mental health or substance use disorders. The Care Management Program shall consist of an Integrated Care Management Program (ICMP) and a Practice Based Care Management (PBCM) program, as set forth in **Section 2.5.B-H**. The Contractor

shall identify Enrollees for both PBCM and the ICMP based on medical risks, behavioral risks and social determinants of health.

2. The Contractor shall offer to collaborate with PCACOs and Behavioral Health Community Partners (BHCPs) for Covered Individuals that are members of PCACOs, as described in **Section 2.5.I.**

3. The Contractor shall offer care coordination support to Covered Individuals not enrolled in the PCC Plan or PCACO as described in **Section 2.5.J**.

4. The Contractor shall support all Covered Individuals that are awaiting disposition in the ED as described in **Section 2.5.K**.

B. Care Management Program for PCC Plan Enrollees

1. Practice Based Care Management (PBCM)

The Contractor shall:

a. Operate Practice Based Care Management (PBCM) in all regions to PCCs and BH Providers serving Enrollees. Expanding PBCM includes providing technical assistance on topics such as approaches to population health management for the high risk/complex Enrollees and strategies to engage Enrollees into care management, as well as support for the provision of care management as needed by the participating practice.

b. Monitor each practice's compliance with the PBCM contract.

c. Submit to EOHHS a plan to promote and increase the number of PCC service locations enrolled in PBCM.

d. The Contractor shall provide direct-to-Provider practice transformation support services for established and expanded PBCMs, including but not limited to, Behavioral Health consultation, Enrollee engagement strategies and supports, population health management strategies, state agency resources, and care management tools.

e. As directed by EOHHS, the Contractor shall enter into a provider arrangement with a specialized provider or organization to provide intensive PBCM to up to 33 Covered Individuals identified by EOHHS with complex and acute medical needs in a fully integrated setting, at a rate to be specified by EOHHS.

2. Integrated Care Management Program (ICMP)

a. The Contractor shall operate an enhanced care management program known as the Integrated Care Management Program (ICMP) for Enrollees with complex medical, mental health and/or substance use disorders.

b. The Contractor shall also identify pregnant and postpartum Enrollees with the following high-risk conditions for outreach and engagement in the ICMP:

1) any history of complex or severe Behavioral Health diagnosis;

2) any history of substance use disorder, including opioids, alcohol, tobacco, or other substances;

3) any current chronic physical health diagnosis which may complicate pregnancy or postpartum (i.e., hypertension, diabetes, HIV, etc.);

4) any history of adverse maternal or neonatal outcomes in previous pregnancies, including any instances of severe maternal morbidity; and/or

5) any current complex social conditions which could impact outcomes during pregnancy or postpartum (i.e., unsafe living environment, significantly late prenatal care initiation, food or housing insecurity, etc.).

c. The Contractor shall identify Enrollees for outreach and engagement in the ICMP through predictive modeling using Behavioral Health, Medical and Pharmacy claim data (historical and current), acceptance of referrals from PCCs, EOHHS staff, Enrollees or other providers for participation in the ICMP, and communication with Enrollees and Providers about ICMP.

d. The Contractor shall provide monthly reports as further specified by EOHHS for Enrollees identified by the Contractor as eligible for ICMP, as well as the methodology by which these members are identified.

e. For each Enrollee in the ICMP, the Contractor shall:

1) Provide Care Management (which are clinical care related services rendered to the member directly either in person or via telephone as per the individual care plan) and Care Coordination (which are care activities rendered by the Contractor on behalf of the Enrollee) to identified Enrollees who have complex medical or Behavioral Health needs and whose overall health care may benefit from the assistance of a Care Manager.

2) provide holistic coordinated health care, social supports, and wellness and recovery tools, and shall assist Enrollees with identifying and using their medical home for treatment of Behavioral Health and medical conditions.

C. Integrated Design for Care Management

1. The Contractor shall submit to EOHHS a work plan for the Contract Year, including timelines, for providing ongoing support for PBCM programs and providing integrated care management for Enrollees served in ICMP. The work plan shall include the supports offered by the Contractor's care management staff related to care management activities provided by PBCMs.

2. The work plan shall be submitted, for review and approval, within two months of the first day of the current Contract Year. This work plan shall:

    a. Prioritize direct real-time referrals to ICMP for high risk Enrollees not served by PBCM programs;

    b. Describe the process of referring Enrollees from ICMP to PBCMs, where appropriate;

    c. Include a description and process for Care Coordination activities within ICMP for those Enrollees in need of primary complex Care Coordination;

    d. Address care management services for those Enrollees transitioning to the community from long term support services;

    e. Address the expansion of PBCM and plan-based programs throughout the Commonwealth to provide care management for Enrollees identified by the Contractor as high risk and eligible for care management, including ICMP among members for whom PBCM is not available;

    f. Include the supports and services offered by the Contractor to Providers who request support from the Contractor for their care management program;

    g. Include an ICMP staffing plan with that includes professional licensed staff, Certified Mental Health Peer Specialists, Recovery Coaches, and community health workers, including the functions to be performed by para-professional staff under the clinical supervision of licensed clinical staff. Licensed staff includes Behavioral Health clinicians and nurses. All ICMP para-professional staff shall be employed directly by the Contractor;

    h. Include the functions of the PCC Support Managers as an ICMP team member; and

    i. Include proposals to provide ICMP to high risk populations other than Enrollees who are pregnant or postpartum.

3. Within three months of the first day of the current Contract Year, the Contractor shall submit to EOHHS any updates in the policies and procedures for daily operation of the care management program.

4. The Contractor shall specifically tailor the care management provided to improve the health outcomes of each Participant, including such items as the frequency and intensity of interventions, and ensuring that the staff assigned to the Participant is appropriate based on each Participant particular needs.

    a. The Contractor shall include in each Participant's plan a range of care management activities that may vary in frequency or intensity depending on the Participant's clinical needs.

    b. The Contractor shall assign a registered nurse, or a Behavioral Health licensed care manager who shall oversee their assigned caseload, perform direct clinical activities and oversee all Care Coordination or support activities performed by para-professional staff.

5. The Contractor shall educate all Participants in self-care strategies, illness prevention and Wellness Program activities, and ensure that staff assigned to the Participant have knowledge of community-based services and supports.

6. Within six (6) months of the beginning of each Contract Year, the Contractor shall evaluate the current ICMP electronic system for tracking, profiling and managing Participants, including but not limited to face-to-face, telephonic, home visits, e-mail, texts, and mail encounter(s) between the care manager and the Participant and submit to EOHHS the results of the evaluation, including data to demonstrate the performance of the current ICMP electronic system and details of improvements that will be pursued.

D. Identification and Engagement of Enrollees for Care Management

1. The Contractor shall use a predictive modeling tool that incorporates health claims data in its algorithm to stratify high risk Enrollees for Enrollment into a PBCM or ICMP. EOHHS may in its sole discretion instruct the Contractor to use EOHHS's risk stratification of the PCC Plan for the Care Management Program. EOHHS may also request from the Contractor its risk stratification data on Enrollees. The Contractor shall work with the PBCM programs to determine sites in need of population-based stratification of high-risk members.

2. The Contractor shall use the Health Needs Assessment (HNA) tool to identify Enrollees who may want to participate in care management.

3. The ICMP shall accept referrals of Enrollees who might be appropriate for care management or who may want to participate in care management from EOHHS, the Contractor's staff, PCCs, state agencies, Enrollees, other Providers, hospital discharge planners, Network Providers, or other knowledgeable sources.

4. The Contractor shall provide each practice offering the PBCM program a monthly list of Enrollees affiliated with the PBCM eligible for care management.

5. The Contractor shall serve high-risk, complex, and specialty populations of Enrollees referred to CMP and not associated with PBCM, unless otherwise requested.

6. The Contractor shall document CMP Engagement activities in-person or telephonic encounters with or on behalf of an Enrollee for the purposes of completing a comprehensive health assessment, creating an Individual Care Plan (ICP), and implementing the Participant's ICP. These care management activities including in-person or telephonic voice-to-voice contact with the Participant must occur no less than once each month while the Participant is enrolled in the Care Management Program. When the Contractor's documented attempts to contact the Participant within thirty (30) days are unsuccessful, the Contractor shall ensure that face-to-face or telephonic voice-to-voice contact with the Participant is made within sixty (60) days.

7. The Contractor shall ensure that Enrollees, PCCs, and Behavioral Health Network Providers are informed about the plan-based Care Management Program in sufficient detail so that Enrollees, PCCs, and Behavioral Health Network Providers understand the program and how to participate.

8. The Contractor shall submit to EOHHS for approval within three (3) months of the beginning of each Contract Year a work plan for informing Enrollees, PCC's and Behavioral Health Network Providers of the plan-based Care Management Program. The work plan shall include a plan for outreach to and Engagement of identified or referred Enrollees.

9. The Contractor shall document the Participant's verbal consent to participate in the Care Management Program, noting the date consent was given, the care management staff to whom the consent was given, and, to the extent that the person giving consent is not the Participant, document the name of the person giving consent and the authority of that person to do so (e.g., "parent" or "guardian"). Additionally, the Contractor shall send a letter to the Participant explaining the Care Management Program in sufficient detail so that the Participant understands the program for which the verbal consent was given and provide sufficient information so that the Participant may opt out.

10. The Contractor shall make available to EOHHS the Contractor's contract with the PBCMs and the outreach, Enrollment and reporting processes expected of PBCMs.

11. On a quarterly basis the Contractor shall provide monthly rosters to EOHHS of all members enrolled and engaged in ICMP or PBCM.

E. Assessment of an Enrollee for Care Management

1. Prior to an assessment for the ICMP, the Contractor shall ensure that Enrollees eligible for participation in PBCM will not be assessed for ICMP.

2. The Contractor shall ensure that an assessment by appropriate health care professionals is conducted for Enrollees identified for care management. The care management assessment shall include the following components:

    a. Assessment of an Enrollee's physical and Behavioral Health status including cognitive functioning and condition-specific issues, including the Enrollee's understanding of their condition-specific issues;

    b. Enrollee's history, needs, and preferences with regard to race, ethnicity, language, culture, literacy, gender identity, sexual orientation, income, housing status, recent incarceration, food insecurity and other social characteristics;

    c. Assessment of the Enrollee's health care utilization patterns, including ED visits, types and variety of Providers who have treated the Enrollee and the Enrollee's diagnoses, if any;

    d. Documentation of clinical history, including medications and response to treatment;

    e. Assessment of risk for violence, suicide, substance use;

    f. Assessment of activities of daily living;

    g. Assessment of life planning activities; and

    h. Evaluation of caregiver resources and natural community supports.

3. A licensed Behavioral Health clinician or a nurse supervisor will determine the type of support an Enrollee needs, including whether the Enrollee requires intensive Care Coordination activities without significant additional care management support. All Care Coordination activities will be documented in an electronic system.

F. Development, Implementation and Monitoring of an Individual Care Plan (ICP) for Care Management

The Contractor shall:

1. Develop required ICPs for, and with, Participants receiving ICMP care management and ensure that an ICP is developed by PBCMs for their Participants.

2. Ensure that the ICMP care manager coordinates a Participant's care across the Contractor's staff, including BH service authorization and BH Utilization Management, and utilizes a multidisciplinary Care Team that includes the Participant, the PCC, and others who are stakeholders in the Participant's care (e.g., family members, Peer Support, BH Providers or other specialists, state

agency case managers and/or service providers, and other community supports), as agreed to by the Participant;

3. Ensure that the ICP addresses the Participant's specific medical and BH care needs and includes the following components:

    a. Long- and short-term goals identified by the Participant and care management team that seek to reduce the risk and help manage the complexity of the Participant's health conditions;

    b. Identification of Barriers to meeting goals and consideration of the Participant's ability to adhere to treatment plans;

    c. Development of a schedule for follow-up and ongoing Participant assessment and communication;

    d. Development and communication of self-management, health promotion, and Wellness Programs for Participant;

    e. Assessment of progress toward meeting goals established in the ICP; and

    f. Behavioral Health Crisis Prevention/Response Plans and Safety and Wellness Action Plan as appropriate.

4. Initiate activities, as indicated in the ICP, related to care management to ensure:

    a. Medication review and reconciliation;

    b. Communication with other treating Providers and other supports identified by the Enrollee;

    c. Comprehensive care transition planning;

    d. Education on self-management of chronic conditions; and

    e. Education and empowerment of Participants and their family support system.

5. Initiate activities, as indicated in the ICP, to ensure Participants' timely and coordinated access to Primary, medical specialty and BH care, such as:

    a. Ensuring access to necessary translation/interpretation services and any other accommodations necessary to assure accessibility of services;

    b. Reinforcement of PCC, specialists or other Network Provider instructions;

    c. Guidance and assistance with obtaining a PCC/medical home for Enrollees when needed;

    d. Assistance in scheduling appointments;

    e. Well-visit and preventive care self-management reminders;

f. Medical and BH appointments reminders and confirmation with the Participant that appointments have been kept;

g. Wellness activities (e.g., smoking cessation, weight loss);

h. Confirming with Participants that they are adhering to medication recommendations;

i. Ensuring certified Mental Health Peer Specialists are available to individuals recommended to receive such services as part of their care plan; and

j. Facilitating communities of social supports available for Participants.

6. Provide the Participant with the opportunity to sign off on or verbally agree to the ICP goals and treatment plan prior to the implementation of such plan. Such plan shall be signed or otherwise approved by the Participant. The Contractor shall establish and maintain policies and procedures to ensure a Participant can sign or otherwise convey approval of his or her ICP when it is developed or subsequently modified. Such policies and procedures shall include:

   a. Informing a Participant of his or her right to approve the ICP;

   b. Providing the Participant with a copy of the ICP;

   c. Providing mechanisms for the Participants to sign or otherwise convey approval of the ICP. Such mechanisms shall meet the Participants accessibility needs;

   d. Informing the Participant of his or her right to an appeal for any Adverse Action related to services included in the ICP; and

   e. Informing the Participant of the availability of Ombudsman services.

7. On at least a monthly basis, assess and monitor each Participant's ICP to ensure that the goals set forth in the ICP are met, the Participant's compliance is monitored, and recommendations for follow-up and all ICP activities are documented in the Participant's ICP.

G. Care Management Activities

The Contractor shall:

1. Assist Providers and Participants in the development of an appropriate ICMP discharge plan when the Enrollee changes treatment settings or is admitted to an in-patient treatment program. The development of a discharge plan shall occur prior to a Participant's hospital or long term care setting discharge or change in treatment setting, in coordination with appropriate staff, including but not limited to discharge planners, care managers, staff, the Participant's PCC, and other

Network Providers. Where possible, the care manager should be present at Discharge Planning meetings for Enrollees within their caseload;

2. Ensure that PBCM providers develop appropriate discharge plans for their Participants transitioning between treatment settings. Complete discharge plans for continuity of care for Participants who transition from ICMP to PBCM or ACO or MCO care management programs;

3. Provide on-going ICMP clinical updates and Care Coordination activities to PCCs and BH Providers for ICMP Participants with complex conditions. The Contractor shall document any clinical information received from the PCC or BH Provider in the ICMP record. The Contractor shall ensure via record review that PBCM providers provide and document clinical updates and Care Coordination activities for their Participants;

4. As necessary for successful Participant Enrollment and tenure, ensure face-to-face contact occurs in home visits, community, inpatient, or emergency department settings, as necessary and appropriate;

5. Facilitate communication among the ICMP Participant, the PCC, the Network Provider and other specialty Providers, and the Participant's support network, as identified by the Participant, who are involved in the Participant's health care, to promote service delivery coordination and improved outcomes;

6. Ensure PBCM programs facilitate communication and service delivery coordination to improve outcomes for their Participants;

7. Monitor medical and pharmacy utilization for ICMP Participants through claims data obtained from EOHHS and appropriately update the ICP and coordinate follow-up care as indicated through data received;

8. Educate and provide to the ICMP Participant and Provider, as appropriate, EOHHS-approved informational materials created by the Contractor or obtained from external sources, about the ICMP Participant's medical or BH condition;

9. Document activities related to the provision of Care Management to ICMP Enrollees and share progress reports with care team members, with written consent from the Enrollees, if required by law; and

10. Prior to any disclosures regarding a Participant made during the provision of care management services, obtain written consent if required by law, and maintain a copy of it in each individual Participant’s files at the Contractor's principal place of business, to the extent required by law.

H. ICMP and Transition to Practice-Based Care Management Programs

The Contractor shall provide either a transition or discharge summary when a Participant transitions to a PBCM from ICMP to encourage a seamless transition and continuity of

care. Such transition or discharge summary shall include but not be limited to a summary of the Participant's care plan, care goals and Barriers to completing care goals. This transition plan can be facilitated face-to-face, telephonically, or through the ICMP clinical meeting.

I. Collaboration with PCACOs and Behavioral Health Community Partners (BHCPs)

1. The Contractor shall collaborate with the PCACOs, as further specified by EOHHS, to support Covered Individuals that are PCACO members. Collaboration shall include but not be limited to:

   a. Care coordination;

   b. Event notification and utilization monitoring;

   c. Quality management and improvement;

   d. Integration of primary care and Behavioral Health;

   e. Risk stratification;

   f. Data collection, analytics, management, and reporting;

   g. Network development and management; and

   h. Other tasks as directed by EOHHS.

2. The Contractor shall collaborate with PCACO-contracted BHCPs, as further specified by EOHHS. Collaboration shall include but not be limited to:

   a. Referring PCACO-enrolled Covered Individuals who may benefit from BHCP support to BHCP, via such systems and processes determined by PCACOs;

   b. Care coordination;

   c. Data collection, analytics, management, and reporting; and

   d. Other tasks as directed by EOHHS.

J. Coordination for Covered Individuals not enrolled in the PCC Plan or a PCACO, including children in care and custody of DCF and DYS

1. The Contractor shall establish clinical protocols for providing Care Coordination to a Covered Individual who is not an Enrollee when:

   a. The Covered Individual presents with a pattern or history of:

      1) high inpatient utilization;

      2) ongoing active involvement with other state agency services and programs;

3) frequent AMCI/YMCI utilization;

4) inconsistent pattern of follow through with outpatient BH treatment;

5) utilization of both psychiatric inpatient and detoxification services; or

6) co-existing medical and BH problems; or

b. The Covered Individual presents to a Network Provider with complex child custody and placement issues that are adversely affecting the provision of Behavioral Health and medical services, inclusive of youth in in the care and custody of the Commonwealth.

2. The Contractor shall accept referrals from EOHHS, PCPs, state agencies, Network Providers, or other knowledgeable sources identifying Covered Individuals who may be appropriate for Care Coordination as described in this **Section 2.5.J**.

3. Within thirty days of the first day of the Contract Year, the Contractor shall submit to EOHHS a work plan for Contract Year One, for the Clinical Service Coordination programs as described in this **Section 2.5.J**, for EOHHS review and approval.

4. The Contractor shall provide Care Coordination for Covered Individuals as follows by:

a. Ensuring that each Covered Individual has a specifically assigned Care Coordinator:

1) With the authority to authorize Covered Services pursuant to the Covered Individual's plan;

2) Who shall convene an interdisciplinary team for service planning meetings; and

3) Who shall work directly with state agency representatives in coordinating care to expedite a timely community placement as part of the Discharge Planning activities described in **Section 2.5.C.5.c**.

b. Ensuring that each Covered Individual has a service plan that addresses the Covered Individual's specific BH care needs, including short-term and long-term service needs and, as applicable, medical services the Covered Individual may require and that coordinates BH services with services provided by other state agencies involved with the Covered Individual;

c. Ensuring that the service plan is sent to the Covered Individual's Primary Care Practitioner after receiving consent, if such consent is required;

d. Facilitating a schedule of home visits and face-to-face contacts with the Covered Individual, if appropriate;

e. Facilitating communication among the Covered Individual, Primary Care Practitioner, Network Providers and other specialty providers involved in the Covered Individual's health care, to promote service delivery coordination and improved outcomes;

f. Providing linkages with staff in other state agencies and community service organizations that may be able to provide services the Covered Individual needs;

g. Assisting the Covered Individual to access Primary Care and medical specialty care;

h. Ensuring that each Covered Individual receives his or her Care Coordinator's contact information;

i. Implementing procedures to coordinate the services that the Contractor furnishes to the Covered Individual:

1) between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays;

2) with the services the Covered Individual receives in fee-for-service Medicaid; and

3) with the services the Covered Individual receives from community and social support providers.

K. Reduction in Covered Individuals Awaiting Disposition in the Emergency Department (ED)

The Contractor shall make best efforts to minimize Covered Individuals awaiting disposition in EDs as follows:

1. The Contractor shall develop a plan to support EOHHS' efforts to reduce Covered Individuals waiting in EDs for disposition to Behavioral Health care. The plan shall include the specific strategies the Contractor shall engage in to reduce transition times from the ED to other services, with a focus on hard to place individuals.

2. The Contractor shall provide timely access to medically necessary, clinically appropriate BH Covered Services for populations determined by EOHHS to be disproportionately boarded in EDs, including but limited to individuals with:

a. Autism Spectrum Disorder-Intellectual Disability (ASD-ID);

b. Developmental and Intellectual Disabilities;

c. Dual Diagnosis for mental health and substance use disorder;

d. Co-morbid Medical Condition; and

e. Assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric setting.

3. When directed and as further specified by EOHHS, the Contractor shall contract with Acute Outpatient Hospital (AOH) EDs to deliver Behavioral Health crisis services to Covered Individuals. When directed and as further specified by EOHHS, create and sustain a network management structure to oversee the provision of Behavioral Health crisis services in AOH EDs.

4. The Contractor shall work in collaboration with PCACOs, PCCs and EDs to facilitate transitions from the ED to other care settings, including supporting providers in identifying appropriate placements. In a form and format and at a frequency to be determined by EOHHS, the Contractor shall report to EOHHS on any Covered Individuals awaiting placements in a 24-hour level of Behavioral Health care who remain in an ED for 24 hours or longer, and the activities the Contractor will take to assist in identifying an appropriate location.

Section 2.6 Covered Services

A. BH Covered Services and Other Benefits

The Contractor shall:

1. Authorize, arrange, coordinate, and provide to Covered Individuals all Medically Necessary BH Covered Services listed in **Appendix A-1**, in accordance with the requirements of this Contract, and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under MassHealth fee-for-service as set forth in 42 CFR 440.230, and, for Covered Individuals under the age of 21, as set forth in 42 CFR subpart B.

2. Inform Covered Individuals of the MassHealth-established access standards for and the availability of Medically Necessary Behavioral Health Covered Services and how to obtain such services.

3. Incorporate the provisions of 130 CMR 450.204 into all criteria for BH Covered Services.

4. Provide all BH Covered Services that are Medically Necessary, including but not limited to those BH Covered Services that:

a. Prevent, diagnose, or treat the Covered Individual's disease, condition, and/or disorder that results in health impairments and/or disability;

b. Assist the Covered Individual to achieve age-appropriate growth and development; and

c. Allow the Covered Individual to attain, maintain, or regain functional capacity.

5. Not arbitrarily deny or reduce the amount, duration, or scope of a required BH Covered Service solely because of diagnosis, type of illness, or condition of the Covered Individual.

6. Coordinate with PCCs and PCACOs to support the provision of other MassHealth covered services included in 130 CMR 450.105 for Covered Individuals.

7. Not be responsible for providing to Covered Individuals or coordinating any Excluded Services as described in **Appendix A-1**.

8. Offer and provide to all Covered Individuals any and all Non-Medical Programs and Services specific to Covered Individuals for which the Contractor has received EOHHS approval.

9. For items or services provided under this Contract, the Contractor shall not cover such services outside the U.S and its territories and shall not provide any payments for such items or services to any entity or financial institution located outside the U.S.

10. Ensure that criminal justice involved Covered Individuals have access to medically necessary BH Covered Services, and Care Management and care coordination as appropriate, as otherwise provided in this Contract.

11. Not impose on a Covered Individual:

a. An annual dollar limit or an aggregate lifetime dollar limit on Behavioral Health Covered Services; and

b. Any QTL, as defined in 42 C.F.R. 438.900, on Behavioral Health Covered Services.

12. In accordance with 42 CFR 457.1201(p), not avoid costs of providing BH Covered Services by referring Covered Individuals to publicly supported Behavioral Health care resources.

B. Services to the Uninsured

The Contractor shall provide Uninsured Individuals and persons covered by Medicare only with Medically Necessary Behavioral Health crisis services without regard to enrollment in with the Contractor.

C. Utilization Management and Authorization of Services

1. General Requirements

a. The Contractor may place appropriate limits on a BH Covered Service based on Medical Necessity, or for the purpose of utilization control, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

1) Developed with input from practicing physicians in the Contractor's Provider Network and experts who are familiar with standards and practices of mental health and substance use treatment for adults, children and adolescents in Massachusetts, including the state substance abuse and mental health authorities (BSAS and DMH);

2) Developed in accordance with standards adopted by national accreditation organizations;

3) Developed in accordance with the definition of Medical Necessity in **Section 1.1** of this Contract and therefore no more restrictive than MassHealth Medical Necessity guidelines, quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs);

4) Evidence-based, if practicable; and

5) Applied in a manner that considers the individual health care needs of the Covered Individual, including but not limited to the ongoing need for services of Covered Individuals with ongoing or chronic conditions;

b. The Contractor shall:

1) Submit the proposed Clinical Criteria to EOHHS for review and approval; and

2) Annually review, and update as necessary, the Clinical Criteria and any other clinical protocols that have been developed, and submit any proposed changes to EOHHS for prior review and approval no less than 60 days prior to any change.

2. Service Authorizations, Utilization Review, Clinical Service Coordination, and Clinical Referral

a. UM Policies and Procedures

1) The Contractor shall develop and maintain UM policies and procedures that ensure Covered Individuals receive the care that is Medically Necessary, and that BH Covered Services are not over-utilized or provided without a determination of Medical Necessity.

Such policies and procedures shall include but not be limited to service authorizations that are consistent with the EOHHS-approved Clinical Criteria the Contractor has developed, and shall adhere to the requirements set forth in this **Section 2.6**.

2) The Contractor shall:

a) Initially, submit the UM policies and procedures to EOHHS for approval at least one month prior to the Operational Start Date.

b) Participate in any EOHHS efforts to standardize UM policies and procedures across EOHHS and its MassHealth managed care entities and fee-for-service programs, including workgroups, task forces, and meetings related to Utilization Management and best practices, as requested by EOHHS.

c) Annually review, and update as necessary and as directed by EOHHS, the UM policies and procedures and submit any proposed changes to EOHHS for prior review and approval no less than 60 days prior to any change.

b. Standards for Clinicians

The Contractor shall ensure the following standards for clinicians who authorize services, unless otherwise approved by EOHHS:

1) The clinician(s) coordinating services and making service authorization decisions must have training and experience in the specific area of service for which they are coordinating and authorizing services.

2) The clinician(s) coordinating and authorizing services for a Covered Individual with a coexisting medical and BH diagnosis must be a registered nurse, psychiatrist, or other licensed clinician with experience and training in services with a coexisting medical and BH diagnosis.

3) In the event a clinician with experience in the specific area of service is unavailable to authorize a service, appropriate clinical consultation must be provided.

c. Service Authorization Procedures

The Contractor shall process requests for initial and continuing authorizations of services which shall:

1) Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a board-certified or board-eligible psychiatrist or health care professional who has appropriate expertise addressing the Covered Individual's Behavioral Health needs, except as provided in **Section 2.6.C.2.c.2** below;

2) In cases of denials of services for psychological testing, require that the denials be rendered by a qualified psychologist;

3) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

4) Consult with the requesting Network Provider when appropriate;

5) Make authorization decisions and provide notice as follows:

   a) For standard authorization decisions, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the Covered Individual's health condition requires and within the following timeframes:

      (i) For Outpatient Services, Outpatient Day Services, and non-24-hour Diversionary Services, the Contractor shall make a decision no later than 14 calendar days following receipt of the request, and shall mail a written notice to both the Covered Individuals and the Network Provider on the next business day after the decision is made; or provide an electronic notification if allowed; and

      (ii) For Inpatient Services and 24-hour Diversionary Services, the Contractor shall make a decision within 24 hours of the request, notify the Network Provider orally within 24 hours, and notify both the Covered Individual and the Network Provider in writing within three days;

   b) For expedited service authorization decisions, where the Network Provider indicates or the Contractor determines that following the standard timeframe in **Section 2.6.C.2.c.5.a** above could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as follows:

(i) The Contractor shall make a decision as expeditiously as the Covered Individual's health condition requires and within 72 hours after receipt of the request for service, with a possible extension not to exceed an additional 14 calendar days. Such extension shall be allowed only if:

(a) the Covered Individual or the Network Provider requests an extension; or

(b) the Contractor can justify (to EOHHS upon request) that (a) the extension is in the Covered Individual's interest, and (b) there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and such outstanding information is reasonably expected to be received within 14 calendar days.

(ii) The Contractor shall notify the Network Provider orally and notify both the Covered Individual and the Network Provider in writing of any denial or decision to authorize services in an amount, duration, or scope that is less than requested on the day that the decision is made.

6) In accordance with 42 CFR 438.3(i) and 422.208, ensure that compensation to individuals or entities that conduct Utilization Management activities for the Contractor are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Individual.

7) Require the Contractor to conduct monthly reviews of a random sample of no fewer than 50 Covered Individuals per month to ensure that such Covered Individuals received the services for which Network Providers billed with respect to such Covered Individuals.

8) Specify that prior authorization shall not be required for the following services as defined in **Appendix A-1**:

a) Inpatient Substance Use Disorder Services (Level 4);

b) Inpatient Mental Health Services. The Contractor must require hospitals to notify the Contractor of the admission

of a Covered Individual for inpatient mental health services and the Covered Individual's initial treatment plan within 72 hours of admission;

c) Community Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT). The Contractor must require CBAT and ICBAT programs to notify the Contractor of the admission of a Covered Individual and the Covered Individual's initial treatment plan within 72 hours of admission;

d) Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7). Medical necessity shall be determined by the treating clinician in consultation with the Covered Individual;

e) Clinical Support Services for Substance Use Disorders (Level 3.5). Medical necessity shall be determined by the treating clinician in consultation with the Covered Individual;

f) Outpatient Couples/Family Treatment, Group Treatment, Individual Treatment, and Ambulatory Detoxification (Level 2.D);

g) Structured Outpatient Addiction Program (SOAP);

h) Intensive Outpatient Program (IOP);

i) Partial Hospitalization (PHP) with short-term day mental health programming available seven days per week;

j) Residential Rehabilitation Services (RRS) (Level 3.1); and

k) Population Specific High Intensity Residential Services (Level 3.1).

9) Require that Providers providing Clinical Support Services for Substance Use Disorders (Level 3.5) and ATS shall provide the Contractor, within 48 hours of a Covered Individual's admission, with notification of admission of a Covered Individual and an initial treatment plan for such Covered Individual. 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 Covered Individual, information regarding the Covered Individual's coverage with the Contractor, and the provider's initial treatment plan. The Contractor may not use

failure to provide such notice as the basis for denying claims for services provided.

10) Specify that concurrent review will not be imposed and coverage for ATS will not be denied based on such review. However, the Contractor may contact providers of ATS to discuss coordination of care, treatment plans, and after care.

11) If utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level 3.5), specify that such activities may be performed no earlier than day 7 of the provision of such services, including but not limited to discussions about coordination of care and discussions of treatment plans. The Contractor may not make any utilization management review decisions that impose any restriction or deny any future Medically Necessary Clinical Support Services for Substance Use Disorders (Level 3.5) unless a Covered Individual has received at least 14 consecutive days of Clinical Support Services for Substance Use Disorders (Level 3.5). Any such decisions must follow the requirements regarding Adverse Action notifications to Covered Individuals and clinicians, as specified in **Section 2.12.B.2**, and processes for Internal and BOH Appeals of the Adverse Action, as specified in **Section 2.12.C**.

12) Allow for at least the first 90 days of Residential Rehabilitation Services for a Covered Individual to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of Residential Rehabilitation Services. The Contractor shall submit for EOHHS's approval the Contractor's authorization and concurrent review procedures for Residential Rehabilitation Services.

d. Notwithstanding any other provision of this Contract, the Contractor shall not authorize services or treatment plans for services to be rendered after the termination of this Contract without EOHHS's prior review and approval, or unless otherwise directed by EOHHS.

3. Clinical Referral and Service Authorization Functions

a. Clinical Referrals Function

To assist Providers and Covered Individuals in identifying Network Providers who can provide BH Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Clinical Referral Line that is staffed 24 hours a day, seven days a week by, at a minimum, bachelor's-level staff who are trained and knowledgeable about

Contractor referral resources and who can make appropriate referral suggestions.

b. Service Authorization Function

1) To authorize delivery of Behavioral Health Covered Services, if appropriate, and to assist Providers and Covered Individuals in identifying Network Providers who can provide Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Service Authorization Line that is staffed 24 hours a day, seven days a week by staff with qualifications as described in **Section 2.6.C.2.b**. Such clinical staff shall have access to Covered Individuals' clinical and service authorization information.

2) The Contractor shall ensure that supervisory staff is available to assist staff clinicians with handling calls to the Service Authorization Line.

3) The Contractor may propose for EOHHS review and approval a plan to adopt an alternative to the Service Authorization Line and/or additional method for Network Providers to request and receive authorization for services.

4) The Contractor shall coordinate service authorization functions with the Care Management Program described in **Section 2.5**, as appropriate.

4. Service Authorization for Specific BH Covered Services

a. Inpatient Service Authorization

The Contractor shall develop Inpatient Service authorization policies and procedures that shall include, at a minimum, the following:

1) A plan and system in place to direct Covered Individuals to the least intensive clinically appropriate service;

2) A system for ensuring that, to the extent permitted by law, authorizations for inpatient admissions occur after a crisis assessment has been conducted by an entity that has been designated by EOHHS and determined that the admission of the Covered Individual is Medically Necessary;

3) Processes to ensure placement for Covered Individuals who require Behavioral Health Inpatient Services when no inpatient beds are available, as described in **Section 2.5.K**;

4) A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 2.6.C.2.c**;

5) A system for ensuring that Inpatient Services are authorized for 24 hours for all Covered Individuals ordered hospitalized by a judge pursuant to M.G.L. c. 123 § 12(e); and that Inpatient Services for such individuals are authorized for more than 24 hours only if the Contractor determines that such services are Medically Necessary;

6) A system of concurrent review for Inpatient Services to monitor the Medical Necessity of the need for continued stay and achievement of Behavioral Health Inpatient treatment goals;

7) A system for addressing Discharge Planning during initial authorization and concurrent review;

8) A system for conducting retrospective reviews of the medical records of selected inpatient authorizations, to assess the Medical Necessity, clinical appropriateness, and appropriateness of the Level of Care and duration of the stay; and

9) A system for ensuring that the Inpatient Services Network Provider asks for the Covered Individual's consent to notify the Covered Individual's PCP that the Covered Individual has been hospitalized.

b. Diversionary Service Authorization

The Contractor shall develop Diversionary Service authorization policies and procedures that shall include, at a minimum, the following:

1) A system that operates 24 hours a day, seven days a week, for authorizing admissions of Covered Individuals to 24-hour Diversionary Services, utilizing the Contractor's Clinical and Medical Necessity Criteria;

2) A system for making clinically appropriate referrals for children and adolescents in need of Community-Based Acute Treatment Services for Children and Adolescents when such Providers have no available beds;

3) A system for authorizing and assigning an initial length of stay for all admissions to 24-hour Diversionary Services, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 2.6.C.2.c**;

4) A system for authorizing non-24-hour Diversionary Services based on Medical Necessity Criteria;

5) A system of concurrent review for 24-hour Diversionary Services to monitor justification and appropriateness of the length of stay, need for continued stay, and achievement of treatment goals;

6) A system for addressing Discharge Planning during initial authorization and concurrent review;

7) A system for ensuring that Network Providers of 24-hour Diversionary Services ask for the Covered Individual's consent to notify the Covered Individual's PCP that the Covered Individual has been admitted; and

8) A system for conducting retrospective reviews of the medical records of selected Diversionary Services cases, to assess the Medical Necessity, clinical appropriateness, and appropriateness of Level of Care and duration of the stay.

c. Outpatient Service Authorization

The Contractor shall develop Outpatient Service authorization policies and procedures that shall include, at a minimum, the following:

1) A system that operates 24 hours a day, seven days a week;

2) A policy and system for automatically authorizing at least 12 outpatient sessions per Covered Individual per Contract Year;

3) A policy and system, secure from unauthorized access, for authorizing outpatient sessions beyond 12 sessions;

4) A policy and system for authorizing Outpatient Services and lengths of treatment based on the Contractor's Clinical Criteria;

5) A policy and system for generally informing Network Providers of the Contractor's protocols for approving Outpatient Services, such as including such protocols in the Provider Manual; and

6) A policy and system to ensure that the provision of outpatient BH Services is based on the individual clinical needs of each Covered Individual, and that the BH Covered Service(s) provided are the least intensive clinically appropriate service(s).

5. Assessment, Treatment Planning and Discharge Planning

a. Assessments

The Contractor shall:

1) Ensure that all Network Providers prepare an individualized written assessment for any Covered Individual entering treatment, regardless of treatment setting.

2) Ensure that assessments are conducted by Network Providers and include but are not limited to:

   a) history of presenting problem;

   b) chief complaints and symptoms;

   c) past BH history;

   d) past medical history, including but not limited to Primary Care, specialty care, treatment for chronic conditions, and use of prescription drugs;

   e) the Covered Individual's family history, social history and linguistic and cultural background, with an assessment of the Covered Individual's identified supports in each of these domains;

   f) for Children in the Care and/or Custody of the Commonwealth, history of placements outside the home;

   g) current substance use;

   h) mental status exam including assessment of suicide and violence risk using industry recognized evidence-based tools (e.g., CSSRS);

   i) current or historical service in the military and/or family of a service member;

   j) current or historical exposure to violence including domestic violence

   k) current or historical exposure to trauma;

   l) previous medication trials, current medications and any allergies;

   m) diagnosis, clinical formulation, rationale for treatment, and recommendations;

   n) level of functioning;

   o) the Covered Individual's strengths and, for children and adolescents, family strengths;

   p) name of PCP and other key Providers; and

q) the Covered Individual's housing status, including if the Covered Individual is homeless or at risk of homelessness.

3) Ensure that when assessments are completed, a multidisciplinary treatment team has been assigned to each Covered Individual. The multidisciplinary treatment team shall, with consent from the Covered Individual, include the following Providers and community supports, as appropriate for the Covered Individual's clinical needs: the PCP current community-based BH Network Providers, other specialists, state agency case managers and/or service providers, Peer Supports identified by the Covered Individual, and others recommended by a team member or requested by the Covered Individual. For children under 18, a parent or legal guardian must be an active participant in the team. The treatment team shall meet to review the assessment and initial treatment plan within the following time frames:

a) For Inpatient Services: within 24 hours of admission;

b) For Diversionary Services: within 48 hours of admission; and

c) For Outpatient Services, for clinics, group practices and solo practitioners, the timeline specified in DPH regulation 105 CMR 140.540.

4) Make best efforts to ensure that the assessments are conducted by Network Providers who have training and experience that match the Covered Individual's clinical needs based on the Covered Individual's presenting problem(s) and diagnosis.

5) Require the clinicians who provide Behavioral Health services described in **Section 2.7.5** to use the CANS Tool and the information gathered from its use to inform treatment planning and Discharge Planning when: providing initial Behavioral Health Clinical Assessments; as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services; and, at a minimum, every 90 days during treatment provided to Covered Individuals who are under age 21.

b. Treatment Planning

The Contractor shall ensure that its Network Providers:

1) Utilize the individualized written assessment, including the clinical formulation, to develop a treatment plan;

2) Develop initial treatment plans that are in writing, dated and signed, and include, at a minimum:

   a) a description of all services needed during the course of treatment;

   b) goals, expected outcomes and time frames for achieving the goals;

   c) indication of the strengths of the individual and his/her family as identified in the assessment;

   d) links to Primary Care and specialty care, especially when there is an active co-occurring medical condition;

   e) when appropriate, the plan to involve a case manager from a state agency, such as DCF, DMH, DYS or DDS; and

   f) treatment recommendations consistent with the service plan of the relevant state agency for Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, DYS youth, or DDS clients.

3) Periodically review initial treatment plans and modify them as necessary;

4) Receive Covered Individual medical and pharmaceutical profiles on a regular basis and use these profiles as part of its periodic review of the Covered Individual's treatment plan;

5) Invite and encourage the following persons to participate in the development and modification of the Covered Individual's treatment plan, the treatment itself, and to attend all treatment plan meetings:

   a) In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, the PCP, Network Providers of BH Outpatient Services, key specialists and other identified supports, but only when the consent of the Covered Individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case the consent of the legal guardian is required.

   b) In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family members, the PCP, Network Providers of BH Outpatient

Services, Family Partners, Care Coordinators, key specialists, and other identified supports.

c) For Covered Individuals who are also DMH Clients, DYS-involved youth, DDS clients or Children in the Care and/or Custody of the Commonwealth, the designated staff from the relevant state agencies.

d) For Covered Individuals who are participating in Care Management through the Contract, the Contractor's assigned care manager.

6) Make best efforts to schedule treatment planning meetings concerning children and adolescents at a time when their family members or guardians are available;

7) Encourage Covered Individuals over the age of 18 to consent to the participation of guardians and family members in the treatment and treatment planning;

8) Assign a multidisciplinary treatment team to each Covered Individual within 24 hours of admission for Inpatient Services or for 24-hour Diversionary Services.

c. Discharge Planning

The Contractor shall:

1) Ensure that all Network Providers, especially Network Providers of Inpatient and Diversionary Services, upon admission of Covered Individuals:

a) assign appropriate designated staff who are knowledgeable about the continuum of coordinated BH and medical services, services and supports in the community, and Discharge Planning;

b) provide notice to the Covered Individual's PCP within one business day of the admission, include the PCP in current Discharge Planning efforts and schedule a follow-up appointment with the PCP for care, as appropriate;

c) coordinate and collaborate with the Contractor's care manager if the Covered Individual is participating in Care Management under the Contractor;

d) make best efforts to ensure a smooth transition to the next service, if any, or to the community;

e) document all efforts related to these activities, including the Covered Individual's active participation in his or her individualized Discharge Planning and, in the case of Covered Individuals under 18, their parent or legal guardian; and

f) Identify Barriers to aftercare and develop strategies to assist Covered Individuals with aftercare services.

2) Develop, in collaboration with each Covered Individual, prior to the individual's discharge from any Inpatient BH Service or, if appropriate, any other BH Covered Service, a written, individualized person-centered, strength-based discharge plan for the next service or program, anticipating the individual's movement along a continuum of services, including availability of Wraparound services for children under 18 and their families;

3) Include in the discharge plan, at a minimum:

a) Identification of the individual's needs, including but not limited to:

(i) housing;

(ii) finances;

(iii) medical care;

(iv) transportation;

(v) family, employment, and educational concerns;

(vi) natural community and social supports; and

(vii) a Crisis Prevention Plan that follows the principles of recovery and resilience, and which may be a component of a Wellness, Recovery Action Plan (WRAP) model for adults and the Risk, Management, Safety Plan for children and their families.

b) A list of the services and supports that are recommended post-discharge;

c) Identified Providers, PCPs and other community resources available to deliver each recommended service;

d) A list of prescribed medication, dosages and possible side effects; and

e) Treatment recommendations consistent with the service plan of the relevant state agency for Covered Individuals who are also DMH Clients, DCF and DYS Youth in the Care and/or Custody of the Commonwealth, or DDS clients.

4) Invite and encourage the following persons to participate in Discharge Planning meetings:

a) In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, PCP, Network Providers of BH Outpatient Services, key specialists, and other identified supports, but only when the consent of the individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case consent of the legal guardian is required;

b) In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family members, PCP, Network Providers of BH Outpatient Services, key specialists and other identified supports;

c) For Covered Individuals who are also DMH Clients, DCF and DYS Youth in the Care and/or Custody of the Commonwealth, or DDS clients, designated staff from the relevant state agencies; and

d) For Covered Individuals enrolled in a PCACO, the Covered Individual's CP, care coordinator, and/or clinical care manager, as applicable;

e) For Covered Individuals receiving Care Management services through the Contractor, the Contractor's assigned care manager.

5) Schedule Discharge Planning meetings concerning children and adolescents at a time when their family members or guardians are available;

6) Develop linkages and policies that create a smooth, clinically sound transition of a Covered Individual's care from one service setting or BH Covered Service to the next, including transition to services provided by state agencies;

7) Assist Covered Individuals in obtaining post-discharge appointments as follows: within seven calendar days of discharge for aftercare services, which may include Outpatient Services as well as a broader range of BH Covered Services, including Non-24-Hour Diversionary Services such as partial hospital programs, if necessary; and within 14 calendar days of discharge for Medication Monitoring, if necessary;

8) Require the treatment team staff responsible for implementing the individual's discharge plan to document the discharge plan in the medical record;

9) Ensure that Network Providers of 24-hour Levels of Care furnish, with appropriate consent, written discharge instructions to the Covered Individual, parents, guardians, residential providers, PCPs, PCACOs, CPs, and relevant state agencies or Contractor care managers at the time of the individual's discharge, to include, without limitation:

   a) a list of prescribed medications and information about any potential medication side effects;

   b) aftercare appointments;

   c) recommended behavior management techniques when applicable; and

   d) a Crisis Prevention Plan, including the toll-free phone number or contact information for the Covered Individual's local CBHC.

10) Ensure that Network Providers of 24-hour Levels of Care furnish, with appropriate consent, a written discharge summary to the Covered Individual, parents, guardians, PCPs, CPs, Contractor care managers, and the Member's current Behavioral Health Providers within two weeks of discharge, to include a summary of:

   a) the course of treatment;

   b) the Member's progress;

   c) the treatment interventions and behavior management techniques that were effective in supporting the Member's progress;

   d) medications prescribed; and

   e) treatment recommendations.

11) Ensure that the discharge plans for Covered Individuals who are DMH Clients are coordinated with the DMH Area or Site Office.

d. Additional Discharge Planning Requirements for Homeless Covered Individuals

The Contractor shall:

1) Strongly discourage Network Providers from discharging Homeless Covered Individuals to shelters;

2) Ensure that all Network Providers provide comprehensive Discharge Planning for Homeless Covered Individuals, and that Network Providers exhaust all potential avenues to secure placement or housing resources, with assistance from the Contractor;

3) Ensure that, within two business days of admission, all Network Providers complete and forward to DMH a DMH Service Authorization packet for Homeless Covered Individuals who appear to meet DMH clinical criteria for service eligibility;

4) Identify community resources for the Homeless Covered Individual and ensure that Network Providers are aware of and utilize all such resources to assist with Discharge Planning for Homeless Covered Individuals;

5) Collaborate with DMH to ensure that Network Providers are aware of and utilize all available DMH resources to assist with Discharge Planning for Homeless Covered Individuals; and

6) Maintain and periodically update website links to Homeless services resources on the Contractor's website to assist Network Providers with Discharge Planning for Homeless Enrollees.

e. Additional Discharge Planning Requirements for Covered Individuals experiencing or at risk of homelessness

The Contractor shall:

1) Ensure that Providers notify the Contractor at the time of admission of a Covered Individual experiencing or at risk of homelessness.

2) Require that, at the time of admission and as part of its general discharge planning processes, each Network Provider assess each admitted Covered Individual's current housing situation. At a minimum, the network provider must assess whether such Covered Individual is experiencing or is at risk of homelessness. To aid in

this assessment, network providers must ensure that their discharge planning staff screen admission data, including but not limited to age, diagnosis, and housing status, within 24 hours of admission. For any Covered Individual determined by the network provider to be experiencing or at risk of homelessness, the network provider must commence discharge planning activities no later than three calendar days after the Covered Individual's admission unless otherwise required to commence such activities at an earlier time following admission.

3) Require that, to assist in the discharge planning process for each Covered Individual experiencing homelessness or at risk of homelessness, the Network Provider, to the extent consistent with all applicable federal and state privacy laws and regulations, invite and encourage the following persons to participate in such Covered Individual's discharge planning activities: the Covered Individual; the Covered Individual's family members; guardians; primary care providers; Behavioral Health providers; key specialists; case managers or other representatives; emergency shelter outreach or case management staff; care coordinators; and any other supports identified by the Covered Individual. For any such Covered Individual who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or the Massachusetts Rehabilitation Commission (MRC), the network provider must, to the extent consistent with all applicable federal and state privacy laws and regulations, invite and encourage designated staff from each such agency to participate in such Covered Individual's discharge planning activities.

4) Require the Network Provider to determine whether any non-DMH-, non-DDS-, or non-MRC-involved Covered Individual experiencing or at risk of homelessness may be eligible to receive services from some or all of those agencies. For any such Covered Individual, the Network Provider must, within two business days of admission, and to the extent consistent with all applicable federal and state privacy laws and regulations, offer to assist the Covered Individual with completing and submitting an application to receive services from DMH, DDS, or MRC, as appropriate.

5) Require that the Network Provider to determine whether any Covered Individual experiencing or at risk of homelessness has any substance use disorder (SUD). For any such Covered Individual, the Network Provider must contact the Massachusetts Substance Use Helpline (800) 327-5050), the statewide, public

resource for finding substance use treatment, recovery options, and assistance with problem gambling, or successor Helplines as identified by EOHHS. The Helpline's trained specialists will help the Covered Individual understand the available treatment services and their options.

6) Require that for any Covered Individual experiencing homelessness who is expected to remain in the Network Provider's facility for fewer than 14 days, the Network Provider contact:

   a) The emergency shelter in which the Covered Individual most recently resided, if known, to discuss the Covered Individual's housing options post discharge; or

   b) The local emergency shelter to discuss the Covered Individual's housing options post discharge if the Covered Individual has not resided in an emergency shelter or if the emergency shelter in which the Covered Individual most recently resided is unknown.

7) Ensure that Providers assess options for discharge as follows:

   a) Network Providers must ensure that their discharge planning staff are aware of and utilize available community resources to assist with discharge planning for Covered Individuals experiencing homelessness or at risk of homelessness;

   b) Network Providers must make all reasonable efforts to prevent discharges to emergency shelters and/or the street of Covered Individuals who have skilled care needs, Covered Individuals who need assistance with activities of daily living, and Covered Individuals whose Behavioral Health condition would impact the health and safety of individuals residing in the shelter. For such Covered Individuals, Network Providers should seek placement in more appropriate settings including DMH community-based programs or skilled nursing facilities;

   c) For certain Covered Individuals, discharge to an emergency shelter or the streets may be unavoidable. For example, certain Covered Individuals may choose to return to the streets or go to an emergency shelter despite the best efforts of the Network Provider. For these Covered Individuals, the Network Provider shall:

(i) Discharge the Covered Individual only during daytime hours;

(ii) Provide the Covered Individual a meal prior to discharge;

(iii) Ensure that the Covered Individual is wearing weather appropriate clothing and footwear;

(iv) Provide the Covered Individual a physical copy of their health insurance information;

(v) To the extent clinically appropriate and consistent with all applicable laws and regulations, provide the Covered Individual with a written copy of all prescriptions and at least one week's worth of filled prescription medications;

(vi) If the Covered Individual is to be discharged to an emergency shelter:

(a) Provide at least 24 hours advance notice to the shelter prior to discharge;

(b) Provide the Covered Individual with access to paid transportation to the emergency shelter;

(c) Ensure that the shelter has an available bed for the Covered Individual. In the event that a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the network provider should delay discharge until a bed is available. In these cases, the hospital may bill the Contractor at the Administratively Necessary Day (AND) rate for each such day on which the Covered Individual remains in the network provider facility.

8) Ensure that Providers adhere to the following discharge planning tracking and reporting activities:

a) Network Providers must document in each Covered Individual's medical record all efforts related to the discharge planning activities described above, including options presented to the Covered Individual and, if applicable, the Covered Individual's refusal of any

alternatives to discharge to the streets or emergency shelters.

b) Network Providers must track discharges of Covered Individuals to local emergency shelters or the streets in a form, format, and cadence to be specified by EOHHS.

9) Notify the Contractor at the time of admission of a Covered Individual experiencing or at risk of homelessness.

6. Utilization Management Services for Review of Services to Additional Populations

a. At the direction of and as further specified by EOHHS, the Contractor shall provide utilization management services to EOHHS to assist in the review and management of services to additional populations, including Members enrolled in MassHealth's fee-for-service program and all MassHealth Members receiving services through court-ordered SUD treatment programs as defined in M.G.L. Chapter 123, Section 35.

b. The Contractor shall work collaboratively with EOHHS to develop utilization management strategies and policies, as further specified by EOHHS.

D. Clinical and Other Support Services

1. Pharmacy Support Services

a. General Requirements

The Contractor shall:

1) As directed by EOHHS, support the initiatives of the MassHealth Pharmacy Program, which manages the pharmacy benefit for PCC Plan Enrollees and other Covered Individuals served under this Contract;

2) Establish and maintain the capability to receive and analyze Claims data received from the EOHHS Data Warehouse for all Covered Services, including pharmacy utilization data for all Covered Individuals;

3) Establish a process to ensure that the Contractor determines the need for care management or care coordination for those individuals who are referred to the Contractor by the MassHealth Drug Utilization Review (DUR) and Pharmacy Program. If the Contractor is unable to reach a Covered Individual, or the Covered Individual declines to participate, the Contractor shall follow up

with the Covered Individual's PCC or prescriber to ensure coordinated care;

4) Ensure that sufficient clinical staff with an understanding of medications(s) and data analytic staff are available to fulfill the pharmacy requirements of the Contract. The Contractor shall have access to a pharmacist on an episodic basis if needed to assist with pharmacy-related projects;

5) Coordinate pharmacy support activities in collaboration with the MassHealth's DUR, and as directed by EOHHS with DMH;

6) The Contractor shall submit the Pharmacy Quarterly Activities Report to MassHealth on the pharmacy-related activities the Contractor has performed in support of this Contract as specified in **Appendix E-1**. This report shall include but not be limited to the following categories of activities:

   a) A summary report of the number of Covered Individuals in each Pharmacy Program initiative that DUR or Office of Clinical Affairs (OCA) staff have referred to the Contractor's Care Management Program and the results of the referral;

   b) Pediatric Behavioral Health Medication Initiative (PBHMI); and

   c) Any other initiatives currently being worked on.

7) For the purposes of this Section, provide Covered Individual-level information described herein only to Providers who have a record of treating the Covered Individual, or otherwise as directed by EOHHS and consistent with all applicable laws and regulations.

b. Pharmacy Initiatives

The Contractor shall support and collaborate with EOHHS on pharmacy activities and efforts, including but not limited to:

1) Using Covered Individuals' drug utilization data obtained from EOHHS to inform and guide prescribing activity, and to improve collaboration by prescribers.

2) Using criteria developed in collaboration with and agreed to by EOHHS, identifying Covered Individuals under the age of 18 on antipsychotic medication who need metabolic monitoring (diabetes and lipid screening test) and notifying both the Covered Individual's prescribing clinician and the PCC, and as further

directed by EOHHS, the Covered Individual's Primary Care ACO, in a form and format and at a frequency specified by EOHHS.

3) At the direction of EOHHS, supporting EOHHS pharmacy initiatives by:

a) Promoting the adoption of MassHealth clinical policy recommendations to PCC Plan Providers, Network Providers and Primary Care ACOs as applicable.

b) Educating PCC Plan Providers and Network Providers regarding the need to coordinate and manage prescribed medication use for BH and medical conditions through an alert, brochure or newsletter.

4) Using criteria developed in collaboration with and agreed to by EOHHS, develop a program to identify prescribers serving Covered Individuals who are currently in the acute stage of opioid therapy and at risk for continued opioid utilization and to develop an early intervention strategy to be used with the identified prescribers.

5) All existing and proposed projects (including all data reports, template letters and notifications) will be reviewed by the Contractor's clinical staff prior to submission to EOHHS. All projects that are implemented need to include an annual QA process to ensure operational soundness and evaluate outcomes.

c. Work Group Participation

1) The Contractor shall assign a pharmacist or other clinician to participate in all appropriate pharmacy work groups as determined necessary by EOHHS, including but not limited to:

a) The DUR Board as well as open DUR workgroups and committees. In the interest of having a multi-disciplinary board, EOHHS prefers that the Contractor sends a Care Manager to these meetings;

b) The Pharmacy Director Meeting Workgroup; and

c) The Pharmacy Advisory Committee Workgroup.

2) The Contractor shall participate in any EOHHS pharmacy strategic planning processes as directed by EOHHS.

d. Obligations of the Contractor to Support Rebate Collection

The Contractor shall take all steps necessary to participate in, and support EOHHS' participation in, federal and supplemental drug rebate programs as directed by EOHHS and as follows:

1) The Contractor shall ensure EOHHS obtains all drug utilization data in accordance with the requirements set forth by EOHHS. The Contractor shall participate and cooperate with EOHHS in activities meant to assist EOHHS with identifying and appropriately including eligible drug claims in the federal drug rebate program.

2) The Contractor shall perform all system and program activities determined necessary to:

    a) Collect all of the following information on claims for physician-administered drugs billed separately using a Healthcare Common Procedure Coding System (HCPCS) by Opioid Treatment Programs, and deny any claim for such drugs that does not include all such information:

        (i) All information set forth in 42 CFR 447.511 that EOHHS specifies the Contractor needs to provide, including but not limited to National Drug Code (NDC);

        (ii) Metric Quantity; and

        (iii) NDC Unit of Measure.

    b) Validate that all National Drug Codes (NDCs) submitted on physician- administered drugs for rebate match the HCPCS being billed for, and include accurate NDC information (unit of measure and quantity);

    c) Properly identify drugs purchased through the Federal 340B Drug Pricing Program by adding the identifier of "UD" to the HCPCS and include this information in the Encounter data;

3) The Contractor shall take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection. Such steps shall include:

    a) Requiring Opioid Treatment Programs to use the preferred products listed on the MassHealth Drug List or as otherwise specified by EOHHS, and changing such designation as directed by EOHHS;

b) Signing up to receive notifications from EOHHS of changes to the MassHealth drug list;

c) Collecting, managing, and reporting this information in Encounter Data as described in this Section and as further specified by EOHHS in **Section 2.14.E** and **Appendix D-1 and D-2**; and future updates to Encounter Data formats as may be issued by EOHHS; and

d) Taking any other steps that are necessary for EOHHS to maximize rebate collection.

e. The Contractor shall provide outpatient drugs pursuant to this Section in accordance with Section 1927 of the Social Security Act and 42 CFR 438.3(s), including but not limited to complying with all applicable requirements related to coverage, drug utilization data, drug utilization review program activities and prior authorization policies.

2. Massachusetts Child Psychiatry Access Program

The Massachusetts Child Psychiatry Access Program (MCPAP) consists of five psychiatric and behavioral consultation programs. Two programs are part of this Contract, and three are part of the companion contract for DMH Specialty Programs. It is expected that any MCPAP specialty programs covered under this Contract will be delivered seamlessly and contractual oversight will be conducted in close collaboration with DMH for those MCPAP programs covered under the 24/7 BH Help Line and DMH Specialty Service Model Contract. The two programs under this Contract include Early Childhood (EC), a psychiatric and Behavioral Health consultation with a sole focus on children age 0 to 5 (for the purpose of the MCPAP Program 0-5 means from birth through age 5) and ASD-ID for MCPAP, which consists of a Behavioral Team and a Statewide Physician Consult Team that help AMCI and YMCI Providers and EDs effectively manage Behavioral Health crises in children and young adults up to age 26 with diagnosed or presumed ASD-ID. Through consultation and education, ASD-ID for MCPAP improves AMCI, YMCI and ED providers' competencies in behavioral assessment and intervention, parent coaching, and in making effective referrals for patients who need community-based services and provides access to pharmacological consultation on an emergency basis.

The Contractor shall:

a. Maintain a network of ASD-ID for MCPAP providers to provide crisis consultation to AMCI/YMCI providers and emergency department providers treating children and young adults with ASD-ID.

b. Maintain ASD-ID for MCPAP teams with optimal staffing patterns to ensure effective team functioning and quality services. The team structure

of ASD-ID for MCPAP, including FTE allocations for ASD-ID for MCPAP Behavioral Teams and Statewide Physician Consult Team, must be approved by EOHHS.

c. Ensure that ASD-ID for MCPAP services are available statewide.

d. In collaboration with EOHHS, develop, implement, and maintain a continuous quality improvement system capable of systematically collecting and analyzing data and information to ensure ASD-ID for MCPAP services are high quality, efficient, and meeting the needs of providers. This CQI system must include the following elements:

   1) Information systems that collect reliable and accurate data;

   2) Clearly defined quality indicators, metrics, and benchmarks that are guided by a logic model;

   3) Rigorous methods for collecting both quantitative and qualitative data;

   4) Analysis of quality data to inform programmatic improvements; and

   5) Timely reports that have up to date information for quality improvement. This includes both routine monthly, quarterly, and annual reports as well as ad hoc reports which respond to a targeted need as requested by EOHHS.

e. Contract with a sufficient number of ASD-ID for MCPAP Behavioral Team and ASD-ID for MCPAP Statewide Physician Consult Team providers to ensure continuous access for AMCI, YMCI and ED providers between 11:00 a.m. to 7:00 p.m., seven (7) days a week (excluding holidays) including the following:

   1) Immediate advice from the ASD-ID for MCPAP Behavioral Team within 30 minutes of the contact or within the time requested by the AMCI, YMCI or ED provider. Ninety-five percent (95%) of all calls to ASD-ID for MCPAP Behavioral Team should be responded to within this time frame.

   2) Immediate advice from the ASD-ID for MCPAP Statewide Physician Consult Team within 30 minutes of the contact or within the time requested by the ASD-ID for MCPAP Behavioral Team. Ninety-five percent (95%) of all calls to ASD-ID for MCPAP Statewide Physician Consult Team should be responded to within this time frame.

3) ASD-ID for MCPAP Behavioral Team available to provide behavioral intervention consultation, including applied behavioral analysis (ABA) to the YMCI provider that is providing 7-day follow up to member.

4) ASD-ID for MCPAP Behavioral Team and Statewide Physician Consult Team available to coordinate follow up activities with the AMCI or YMCI provider that is providing 7-day follow up to member.

5) Schedule a patient face-to-face or telehealth assessment with an ASD-ID for MCPAP Statewide Physician Consult Team provider within 5 business days of the referral date or schedule a face to face or telehealth assessment with an ASD-ID for MCPAP Behavioral Team LABA within 1 business day of the referral date. To assess these standards for timely face-to-face or telehealth assessments, on a monthly basis, the Contractor shall contact the ASD-ID for MCPAP Behavioral Teams and Statewide Physician Consult Teams to receive the prospective wait time for the first available and second available appointment dates from the date of the Contractor's contact with the Teams.

6) Submit to EOHHS and implement a quality improvement plan that describes root causes and identifies corrective action steps by the 30th of the month following the quarter if either of the following occurs:

a) If response time for an ASD-ID for MCPAP Behavioral Team is lower than 95% consistently for a quarter;

b) If response time for ASD-ID for MCPAP Statewide Physician Consult Team is lower than 95% consistently for a quarter.

f. Perform the following ongoing responsibilities, without limitation:

1) Collect Encounter data pursuant to the Contractor's requirements;

2) Conduct outreach to recruit, enroll, and build relationships with AMCIs, YMCIs and ED providers;

3) Inform AMCIs, YMCIs and ED providers in a MCPAP Team's region how to access MCPAP services;

4) Annually survey AMCIs, YMCIs and ED providers regarding satisfaction with MCPAP;

5) Maintain program-specific dedicated websites about the ASD-ID for MCPAP that provide information about the program and information about Behavioral Health topics and resources;

6) Conduct outreach and trainings for AMCI, YMCI, and ED providers and other Behavioral Health first responders to develop their knowledge and skills to treat youth and adults with ASD-ID.

7) Create public awareness campaign about the availability of the ASD-ID for MCPAP service for families of individuals with ASD-ID, staff at Autism Support Centers, pediatric providers, parent resource groups, and other stakeholders as directed by EOHHS.

g. Submit ASD-ID for MCPAP monthly, quarterly, and annual aggregate progress reports to EOHHS identified in and according to the reporting schedule in **Appendix E-1**.

h. Submit annual itemized budgets for the ASD-ID Program by December 31st of each calendar year, and whenever there is a change in the budget.

i. Coordinate all ASD-ID for MCPAP program activities with EOHHS, including but not limited to:

1) Revising program activities as requested by EOHHS and approved by EOHHS; and

2) Participating in any EOHHS-initiated program evaluation activities and accompanied recommendations for future direction.

j. For January 1 and 2, 2023, and until otherwise notified by EOHHS, ensure the availability of ASD-ID for MCPAP program for ESP providers, as otherwise specified in this Section.

k. Establish and maintain an Early Childhood (EC) MCPAP team to increase availability of supports and access to treatment for children aged 0 through 5 with Behavioral Health needs and their families. The team will include:

1) The Medical Director, at 0.15 FTE, who will provide supervision to the Early Childhood Mental Health Clinician and Child Psychiatrist. In partnership with DPH, she will develop educational materials and curriculum focused on early childhood mental health and secondary prevention for the ECHO (a professional development model that combines didactic training, case presentation by a participant with feedback and resources provided by the participants and faculty) training and case consultation model to be piloted with pediatric PCPs, and to be used to expand the model to all MCPAP regions.

2) A Child Psychiatrist, at 0.1 FTE, will provide evaluation, using the multi-axial Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5), and short-term treatment of children 3-5 years old referred for medication management consideration.

3) A licensed Behavioral Health Clinician with expertise/training in early childhood mental health, at 1.0 FTE, who will respond to phone queues from pediatric PCP referred for phone consultation. This position will provide evaluation, using the multi-axial Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0-5. The clinician will also provide on an as needed basis short-term treatment of children 0-5 years old (up to age 6) referred for behavioral assessment and management, as well as resource and referral services.

4) A Program Coordinator, at 0.5 FTE, who will respond to phone calls and messages, initiate queues, and manage scheduling. This position will also support coordination of ECHO, a professional development model that combines didactic training, case presentation by a participant with feedback and resources provided by the participants and faculty.

l. Oversee the building of the EC MCPAP Team which will be housed and administered in the MCPA Central Hubs. The EC MCPAP services area will include the Central and Western hubs.

m. Provide expanded EC MCPAP telehealth consultation to pediatric Primary Care Practitioners (PCPs), including Primary Care Clinicians (PCCs), treating pediatric Members who may need Behavioral Health services with an initial focus on practices in MCPAP Central and Western hubs. Consultation shall include:

1) An assessment of Behavioral Health needs of children ages 0-5 years for enrolled providers within the Central and Western hubs as specified above. This assessment shall include:

a) Revision of the MCPAP annual survey to providers to add additional questions specific to critical needs of children 0-5 years old with Behavioral Health needs as well as their preferred mechanism for receiving consultation, including any post-pandemic changes; and

b) Specific outreach to providers in the Western and Central hubs to participate in two ECHO programs: one on Early

Childhood Behavioral Health and one on the Pyramid in Primary Care, which will be developed with content adapted from the national Pyramid Model for Promoting Social Emotional Competence in Infants and Young Children.

2) Development and implementation of communication process for Pediatric Primary Care Providers (PPCPs) and other stakeholders, utilizing MCPAP's websites, webinars and other communication channels;

3) Adoption of practices to ensure family support and racial health equity with guidance from DPH; and

4) Provision of EC MCPAP telehealth consultation, assessment, referrals, and brief treatment using DC:0-5 assessment of children 0-5 years old.

n. Develop and implement EC MCPAP training, as follows:

1) Develop curriculum, do outreach and recruitment, enroll providers, and implement ECHO virtual clinics for pediatric and other providers; include DPH Early Childhood Systems Coordinator for Family Engagement and Training in planning and implementation;

2) Work with DPH on the creation and implementation of the Pyramid in Primary Care (PiPC) modules, and family engagement training using the ECHO approach and learning communities for integrated primary care teams to support outreach and recruitment of integrated care teams;

3) Work with DPH and family leaders to support development and dissemination of the PiPC Toolkit;

4) Partner with DPH to develop and implement training or webinars on additional topics in response to the annual training needs assessments; and

5) Work with DPH to ensure family voice and a racial equity lens in all online or in-person trainings, including having a person with lived experience as a co-presenter or responder in all training programs.

o. Enhance and expand EC MCPAP referral network and community-based resources, as follows:

1) Coordinate with DPH and partners to expand referral network of early childhood mental health (ECMH) clinicians trained in

Evidence Based Treatment models (EBTs) (including DC:0-5); and

2) Expand referral network and listings for IECMH services and other community resources, including Pyramid Model sites and family support resources and groups by coordinating with DPH and partners.

p. Promote equitable access for children ages 0-5 to EC MCPAP and the IECMH system of care as follows:

1) Build linkage with MCPAP for Moms and other perinatal providers for referrals of infants to EC MCPAP and for training on IECMH;

2) Build capacity of other MCPAP hubs through consultation and training by EC MCPAP and regional PCP champions, focusing on underserved areas; and

3) Increase amount and effectiveness of data collection on race and ethnicity and use of this data in CQI efforts (including use of DPH Racial Equity Data Roadmap), including:

a) Continue CQI project on collecting patient race and ethnicity data; and

b) Track education/training data, including registration, on race and ethnicity of enrolled providers in attendance;

q. Sustain, and integrate EC MCPAP with the early childhood system of care and expand program statewide, as follows:

1) Conduct regular assessment of EC MCPAP capacity to serve, including an annual report with a plan for sustainability;

2) Participate in IEMCH Policy Workgroup, Young Children's Council, and other efforts;

3) Align EC MCPAP with other MCPAP programs; and

4) Disseminate information about the project with DPH at conferences and through publications.

r. As directed by DPH and in conjunction with EOHHS, coordinate with and report to DPH on all EC program activities, including but not limited to:

1) Participating in regular planning meetings and other meetings as required by DPH and project activities;

2) Utilizing feedback from Young Children's Council, the EC MCPAP Advisory Committee, to inform and advise MCPAP and on program improvements and direction;

3) Revising program activities as requested by DPH or EOHHS and approved by EOHHS;

4) Participating in any DPH or EOHHS-initiated program evaluation activities and accompanied recommendations for future direction;

5) Providing data from MCPAP Live to respond to Health Resources and Services Administration (HRSA) performance measures in the reporting template as specified by DPH on a quarterly basis;

6) Making any enhancements to the data base that are needed for the project, e.g., amending the data elements for the provider education segment specific to the 0-5 age group; and

7) Providing quarterly expenditure reports to DPH on spending of the EC MCPAP program in Central Hub submitted to DPH to ensure compliance with HRSA's financial reporting requirements;

s. As further directed by EOHHS, the Contractor will submit an annual report to DPH and EOHHS which meets the HRSA reporting requirements. The track and report on the following performance measures using information reported from the prior year as a baseline:

1) Number of trainings held by topic and mechanism (e.g., in-person, web-based);

2) Number and types of providers training type (e.g., Project ECHO, other distance learning training, in-person training);

3) Number and types of providers enrolled in a statewide or regional pediatric mental health care access program;

4) Percentage of primary care providers enrolled in a statewide or regional pediatric mental health care access program who receive tele-consultation on Behavioral Health conditions;

5) Reasons for provider contact with the pediatric mental health team (e.g., psychiatric consultation and/or care coordination, and suspected or diagnosed Behavioral Health conditions such as depression, anxiety, ADHD, or Autism Spectrum Disorder);

6) Course of action to be taken by provider as result of contact with the pediatric mental health team and number of times each course of action was recommended (e.g., medication evaluation/change, use of screening tool or instrument, referral to community-based

support services or resources, referral to Behavioral Health provider);

7) Number of consultations and referrals provided to enrolled providers by the pediatric mental health team, by enrolled provider discipline type, and by telehealth mechanism (e.g., telephone, videoconferencing, email);

8) Number of consultations and referrals provided by each discipline type (e.g., psychiatrist, counselor, care coordinator) of the pediatric mental health team;

9) Number and types of community-based mental health and support service and service providers in the telehealth referral database (e.g., childcare, employment/job-seeking training, food programs, housing support, parenting support, school-based services, Behavioral Health services, inpatient and outpatient treatment programs; inpatient hospitalization or emergency department; all other clinical provider services including medication management; and all other service or service provider types);

10) Types of referrals provided by the pediatric mental health team (e.g., Behavioral Health services, inpatient and outpatient treatment programs; inpatient hospitalization or emergency department; other clinical provider services including medication management; school-based services; parenting support);

11) Number of children and adolescents, age 0–21, and a subset of children 0 through 5 years of age, for whom a provider contacted the pediatric mental health team for consultation or referral during the reporting period;

12) Number of referrals provided to children and adolescents aged 0–21, and a subset of children 0-5 years of age, for whom a primary care provider contacted the pediatric mental health team during the reporting period;

13) Number of children and adolescents, age 0–21 and a subset of children 0 through 5 years of age, for whom a provider contacted the pediatric mental health team, who received at least one screening for a Behavioral Health condition using a standardized validated tool;

14) Percentage of children and adolescents, 0–21 and a subset of children 0 through 5 years of age, for whom providers contacted the pediatric mental health team for consultation or referral during the reporting period, from rural and underserved counties;

15) Number of children and adolescents, 0–21 and a subset of children 0 through 5 years of age, for whom a primary care provider contacted the pediatric mental health team during the reporting period, who were recommended for referral to a behavioral clinician or treatment from the primary care provider; and

16) Number of children and adolescents, age 0–21 and a subset of children 0 through 5 years of age, for whom a primary care provider contacted the pediatric mental health team during the reporting period, who screened positive for a Behavioral Health condition using a validated tool, and who were recommended for referral to a behavioral clinician or treatment from the primary care provider.

3. Crisis Service Safety Initiative

The Contractor shall administer the Crisis Service Safety Initiative by providing oversight to the Living Room Model as directed by EOHHS and DMH, ensuring that providers receiving these grants:

a. Provide a 24/7 peer supported recovery environment for individuals 18 and older who are experiencing a crisis as an alternative to emergency services or traditional crisis stabilization services, as no cost to the individual for no longer than 24 hours per encounter.

b. Staff the Living Room Model with Certified Peer Specialists who have received training in alternative crisis intervention techniques.

4. Medication for Opioid Use Disorder (MOUD) Access and Pain Management Support

The Contractor shall develop a network of MOUD expert prescribers and pain management specialists to support primary care providers as follows:

a. The Contractor shall develop a virtual consult (phone or video) system to link primary care providers requesting consult with MOUD experts and pain management specialists for support or consultation.

b. The Contractor shall maintain a central help desk to connect primary care providers to such experts and specialists.

c. The MOUD experts identified by the Contractor shall provide consultation on MOUD including, but not limited to:

1) MOUD initiation;

2) MOUD management (e.g., titration for existing patients);

3) Dosing;

4) Appropriate prescribing for patients on more than one medication;

5) Prescribing guidance for vulnerable populations with increased risk of diversion; and

6) Support for clinical presentation of complex cases for MOUD medication.

d. The pain management specialists identified by the Contractor shall provide consultations on pain management, including but not limited to:

1) Pain management prescribing (e.g., initial prescription, weaning patient off of or changing prescription);

2) Dosing;

3) Appropriate prescribing for patients on more than one medication;

4) Prescribing guidance for vulnerable populations with increased risk of diversion; and

5) Support clinical presentation of complex cases for pain management.

e. As directed by EOHHS, the Contractor shall develop strategies for increasing provider utilization of the consultations on MOUD and pain management set forth in this **Section 2.6.D.4**, which shall include, but not be limited to:

1) MOUD and Pain Management Specialists to place follow-up calls to training programs to enhance training support resources;

2) MOUD and Pain Management Specialists to place follow-up calls to practices that have requested consultations in the past;

3) MOUD and Pain Management Specialists to present at hospital grand rounds or other hospital presentations;

4) MOUD and Pain Management Specialists to staff and manage monthly "office hours" where clinicians can call in for a group discussion; and

5) Enhancing promotional materials, including but not limited to developing a clinical manual for dissemination.

f. As directed by EOHHS, the Contractor shall provide case management and care navigation support to assist healthcare facilities, individual practitioners and other healthcare providers including, but not limited to, nurse case managers, social workers and recovery coaches in identifying

community-based providers to refer patients for treatment of substance use disorder.

g. As directed by EOHHS, the Contractor shall annually submit to EOHHS a comprehensive evaluation of the MOUD and Pain Management Consultation programs, including but not limited to a provider satisfaction survey and member follow-ups to document outcomes.

5. Community Support Program for Homeless Individuals (CSP-HI)

a. Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP-HI services as set forth in **Appendix A-1** to Covered Individuals who meet one of the following criteria:

1) Homeless Covered Individuals who meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or

2) Homeless Covered Individuals who do not meet the "Chronically Homeless" definition under **Section 2.6.D.5.a.1** above and who are also high utilizers of MassHealth services as defined by MassHealth.

b. The Contractor shall:

1) Authorize, arrange, coordinate, and provide CSP-HI services as set forth in **Appendix A-1** to Covered Individuals who meet the criteria under **Section 2.6.D.5.a.**

2) Actively communicate with CSP-HI providers regarding the provision of CSP-HI services to Covered Individuals, including coordinating care to ensure that Covered Individuals' needs are met;

3) Require that Network Providers of CSP-HI have demonstrated experience and employed staff as further specified by EOHHS including Homelessness experience and expertise;

4) Develop Performance Specifications for the delivery of CSP-HI as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

5) Pay CSP-HI providers a daily rate for each Covered Individual. Once the Covered Individual has obtained housing, continue to pay CSP-HI providers the daily rate until such a time as the Contractor determines that CSP-HI is no longer medically necessary;

6) Ensure that rates paid for CSP-HI services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;

7) Designate a single point of contact for CSP-HI to provide information to CSP-HI providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contact designated for CSP-TPP as described in **Section 2.6.D.6.b.7**; and

8) Collect and maintain written documentation that the Covered Individuals receiving CSP-HI meet the definitions under **Section 2.6.D.5.a** as further specified by EOHHS including:

a) Documentation of "chronic homelessness" and "homelessness" shall meet the HUD standards for recordkeeping and be generated from the local Continuum of Care Homeless Management Information System (HMIS). If HMIS records are not available, the Contractor may collect other documents to prove chronic homeless or homeless status, but these shall meet the HUD standards for determining and documenting homelessness; and

b) Documentation of high utilization of Covered Behavioral Health services shall be generated by the Contractor.

c. The Contractor shall require that any staff of network providers of CSP-HI meet the following minimum qualifications:

1) Specialized training or lived experience in Behavioral Health treatment for co-occurring disorders, trauma-informed care, and Traumatic Brain Injuries;

2) Specialized training or experience in outreach and engagement strategies such as progressive engagement, motivational interviewing, etc.; and

3) Knowledge of housing resources and dynamics of searching for housing.

6. Community Support Program (CSP) Tenancy Preservation Program

a. Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall provide CSP-TPP services as set forth in **Appendix A-1** to Covered Individuals who are unstably housed. For the purposes of this Section "unstably housed" is defined as a Covered Individual who:

1) Has a lease violation directly related to the Covered Individual's Behavioral Health;

2) Is at risk for eviction, as documented by a Notice to Quit or a Notice of Lease Termination (in public housing); and

3) Has a preservable tenancy.

b. The Contractor shall:

1) Authorize, arrange, coordinate, and provide CSP-TPP services as set forth in **Appendix A-1** to Covered Individuals who meet the criteria under **Section 2.6.D.6.a**;

2) Actively communicate with CSP-TPP providers regarding the provision of CSP-TPP services to Covered Individuals, including coordinating care to ensure that Covered Individuals' needs are met;

3) Require that Network Providers of CSP-TPP have demonstrated experience and employed staff as further specified by EOHHS;

4) Develop Performance Specifications for the delivery of CSP-TPP as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;

5) Pay CSP-TPP providers a daily rate and continue to pay CSP-TPP providers the daily rate until such a time as the Contractor determines that CSP-TPP is no longer medically necessary;

6) Ensure that rates paid for CSP-TPP services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;

7) Designate a single point of contact for CSP-TPP to provide information to CSP-TPP providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same

contact designated for CSP-HI as described in **Section 2.6.D.5.b.7**; and

8) Collect and maintain written documentation that the Enrollees receiving CSP-TPP meet the definitions under **Section 2.6.D.6.a** as further specified by EOHHS.

7. Community Support Program for Individuals with Justice Involvement

a. Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall authorize, arrange, coordinate, and provide CSP-JI services as set forth in **Appendix A-1** to Covered Individuals with justice involvement that consist of intensive, and individualized support delivered face-to-face or via telehealth as further specified by EOHHS, which shall include:

1) Assisting in enhancing daily living skills;

2) Providing service coordination and linkages;

3) Assisting with obtaining benefits, housing and healthcare;

4) Developing a safety plan;

5) Providing prevention and intervention; and

6) Fostering empowerment and recovery, including linkages to peer support and self-help groups.

b. For the purpose of this **Section 2.6.D.7**, individuals with justice involvement shall be those Covered Individuals released from a correctional institution within one year, are under the supervision of the Massachusetts Probation Service, or are under the supervision of the Massachusetts Parole Board.

c. The Contractor shall, as further directed by EOHHS, with respect to CSP-JI:

1) Actively communicate with CSP-JI Providers regarding the provision of CSP-JI services, including coordinating care to ensure that individuals' needs are met;

2) Ensure that Network Providers of CSP-JI have demonstrated experience and engage in specialized training;

3) Report to EOHHS about its Network Providers of CSP-JI in accordance with **Appendix E-1**; and

4) Designate a single point of contact for CSP-JI to provide information to CSP-JI providers and EOHHS as further specified by EOHHS.

5) Maintain agreements with BH-JI Providers identified by EOHHS who provide in-reach services.

8. Preventive Behavioral Health Services

The Contractor shall cover medically necessary preventive Behavioral Health services for members from birth until age 21, or their caregiver, as outlined in **Appendix A-1**, and in **MassHealth Managed Care Entity Bulletin 65** or as further specified by EOHHS. The Contractor shall cover up to six sessions of preventive Behavioral Health services without requiring prior authorization or a diagnostic assessment, such as the CANS (Child and Adolescent Strengths and Needs). After six sessions, the Contractor may require the provider to submit documentation to support the clinical appropriateness of ongoing preventive services. The Contractor may require providers to complete a diagnostic assessment, including the CANS, as part of the Contractor's determination of the ongoing need for preventive services. The Contract shall pay providers no less than the rate set forth in **Appendix L** for these services and shall require providers to utilize the code and modifier combination set forth in **Appendix L** when billing for such services.

9. Intensive Hospital Diversion Program

The Contractor shall make available the intensive hospital diversion (IHD) program, through its network of qualified In-Home Therapy providers, for youth up to age 21, as an alternative to 24-hour level of care. The program will support a youth in crisis after the initial crisis evaluation and intervention has been rendered. The program shall provide intensive, short-term therapy to stabilize youth and their families without the need for hospitalization and to establish new or engage existing Children's Behavioral Health Initiative (CBHI) services and other Behavioral Health services to maintain the youth in the community.

10. Behavioral Health Urgent Care Program

a. The Contractor shall manage a quarterly attestation process for mental health centers or other providers, as directed by EOHHS, to become designated Behavioral Health Urgent Care providers. The attestations must include assurances that the mental health center meets the following requirements:

1) Provide same or next day appointment available for diagnostic evaluation for new clients;

2) Provide same or next day urgent appointments for current clients;

3) Provide urgent psychopharmacology appointments and MAT or MOUD evaluation access within 72 hours, as needed based on a psychosocial assessment;

4) Provide other treatment appointments within 14 calendar days;

5) Provide extended clinical availability outside of the hours of 9am-5pm, including:

   a) Eight (8) hours of extended availability per week during weekdays;

   b) Two 4-hour blocks of availability on weekends per month

6) Each quarter, the Contractor shall collect the following reports from the designated Behavioral Health Urgent Care providers, stratified by months:

   a) Percentage of total quarterly visits provided during extended appointment hours

   b) Percentage of total quarterly initial evaluations completed within 1 day of clinic operation following the first contact

   c) Percentage of total quarterly initial evaluations completed during extended appointment hours

   d) Percentage of total quarterly urgent visits for existing clients completed within 1 day of clinic operation

   e) Percentage of total quarterly urgent visits completed within 1 day of clinic operation occurring during extended appointment hours

   f) Percentage of total quarterly urgent psychopharmacology appointments that occur within 72 hours of initial diagnostic evaluation

   g) Percentage of total quarterly Medication for Addiction Treatment appointments that occur within 72 hours of initial diagnostic evaluation

   h) Percentage of total quarterly routine or follow-up visits completed within 14 calendar days of initial contact; and

   i) Percentage of total quarterly routine or follow-up visits completed within 14 calendar days of initial contact that occur during extended appointment hours

b. The Contractor shall conduct an annual analysis and summary of the Behavioral Health Urgent Care Program Member Experience Survey

c. The Contractor shall pay Behavioral Health Urgent Care providers designated by EOHHS a uniform 15% increase over the Contractor's negotiated rates for all applicable codes.

11. Emergency Department-Based Behavioral Health Crisis Evaluation Services

When further specified by EOHHS, the Contractor shall pay hospitals directly for ED-based behavioral health crisis evaluations at no less than the rate specified by EOHHS. The Contractor shall not make payments to AMCI and YMCI teams for BH crisis evaluations provided in the Emergency Department unless otherwise directed by EOHHS. Hospitals may sub-contract these services out to behavioral health providers, including crisis teams, but hospitals shall be solely responsible for billing the Contractor unless otherwise directed by EOHHS.

E. In Lieu of Services or Settings

1. The Contractor may cover the Inpatient Services set forth in **Sections I.A., II.A., and III.A. of Appendix A-1** delivered in Institutions for Mental Disease (IMD), as defined in Section 1905(i) of the Act, as an in lieu of service or setting for Enrollees between the ages of 21 through 64, provided that:

a. The Contractor does not require enrollees to receive services in an IMD;

b. Use of an IMD is a medically appropriate and cost-effective substitute for delivery of the service; and

c. The length of stay for any Enrollee is no more than 15 days in a calendar month.

2. For any Enrollee between the ages of 21-64 who received the Inpatient Services set forth in **Sections I.A., II.A., and III.A of Appendix A-1** in an IMD for more than 15 days in any calendar month, the Contractor shall:

a. Report to EOHHS, in a form and format and at a frequency to be determined by EOHHS:

1) The Enrollee's rating category;

2) The length of stay in the IMD in that calendar month; and

3) Any other information requested by EOHHS.

b. As further specified and directed by EOHHS, reconcile the capitation payment received by the Contractor pursuant to **Section 4** and **Appendix H-1** for the calendar month in which the Enrollee received the Inpatient Services set forth in **Sections I.A., II.A., and III.A of Appendix A-1** in an IMD for more than 15 days.

Section 2.7 BH Provider Contracts and Related Responsibilities

A. BH Provider Contracts General Requirements

The Contractor shall:

1. Maintain all Provider Contracts and other agreements and subcontracts relating to this Contract, including single case agreements with out of network providers, in writing.

    a. All such agreements and subcontracts shall fulfill all applicable requirements of 42 CFR Part 438 and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity. Without limiting the generality of the foregoing, the Contractor shall ensure that all Provider Contracts and contracts with out of network providers include the following provision: *"Providers shall not seek or accept payment from any Covered Individual for any BH Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any BH Covered Service rendered to a Covered Individual. Instead, Providers shall look solely to the (Contractor's name) for payment with respect to BH Covered Services rendered to Covered Individuals. Furthermore, Providers shall not maintain any action at law or in equity against any Covered Individual or EOHHS."*

    b. The Contractor shall not acquire established networks without executing a Provider Contract with each Provider that complies with all of the provisions of this Contract and contacting each Provider to ensure that the Provider understands the requirements of this Contract and agrees to fulfill all terms of the Provider Contract. In Provider organizations where the organization represents the Provider in business decisions, a Provider Contract with the Provider organization shall be sufficient to satisfy this requirement.

2. Require a National Provider Identifier on all claims and provider applications;

3. 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), and

4. With respect to all Provider Contracts, comply with 42 CFR 438.214 Provider selection, including complying with any additional requirements as specified by EOHHS;

5. Require all Providers to provide a Covered Individual's clinical information to other Providers, as necessary, to ensure proper coordination and BH treatment of

Covered Individuals who express suicidal or homicidal ideation or intent, consistent with state law;

6. Require Behavioral Health Providers to submit to the Contractor a written report of all Reportable Adverse Incidents in accordance with **Appendix E-1**, or in another form and format acceptable to EOHHS;

7. Require the use of any standardized clinical assessment tools by substance use disorder treatment providers as directed by EOHHS;

8. Ensure that all Provider Contracts prohibit Providers from:

    a. Billing Covered Individuals for missed appointments or refusing to provide services to Covered Individuals who have missed appointments. Such Provider Contracts shall require Providers to work with Covered Individuals and the Contractor to assist Covered Individuals in keeping their appointments;

    b. Billing patients for charges for BH or non-BH Covered Services;

    c. Refusing to provide services to a Covered Individual because the Covered Individual has an outstanding debt with the Provider from a time prior to the Covered Individual becoming a MassHealth Member;

    d. Closing or otherwise limiting their acceptance of Covered Individuals as patients unless the same limitations apply to all commercially insured enrollees.

9. Ensure that all Provider Contracts specify that:

    a. No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition;

    b. As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 CFR 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;

    c. The Contractor shall not refuse to contract with or pay an otherwise eligible health care provider for the provision of BH Covered Services solely because such Provider has in good faith:

        1) Communicated with or advocated on behalf of one or more prospective, current or former patients regarding the provisions, terms or requirements of the Contractor’s BHP as they relate to the needs of such Provider's patients; or

2) Communicated with one or more 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;

d. No contract between the Contractor and a Provider may contain any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay or limit specific, Medically Necessary Services;

e. A 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;

f. When a Provider contract is terminated for any reason, a Provider must assist with transitioning Covered Individuals to new Providers, including sharing the Covered Individual's medical record and other relevant Covered Individual information as directed by the Contractor or Covered Individual;

g. The Contractor shall provide a written statement to a Provider of the reason or reasons for termination with cause;

h. Providers shall participate in Contractor's continuity of care policies and procedures as described in **Section 2.2.C**;

i. Contracts between the Contractor and Providers shall require Providers to comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and access and availability of services, and

j. Contracts between the Contractor and Providers shall require Providers to comply with the accessibility standards as described in **Section 2.9**.

B. Additional Responsibilities for BH Providers that Serve Covered Individuals under Age 21

For Network Providers that serve Covered Individuals under age 21, the Contractor shall enter into and oversee Provider Contracts with Network Providers who provide Behavioral Health Services that include the following requirements:

1. The Contractor shall ensure that such Provider Contracts shall require that clinicians, including psychiatrists, psychiatric residents, psychiatric nurse mental health clinical specialists, psychologists, Licensed Independent Clinical Social Workers (LICSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Mental Health Counselors (LMHCs), Licensed Marriage and Family

Therapists, (LMFTs), Licensed Clinical Social Workers (LCSWs), and unlicensed Master's level clinicians working under the supervision of a licensed clinician, who provide Behavioral Health Services to Covered Individuals under the age of 21 in certain levels of care, including Diagnostic Evaluation for Outpatient Therapy (individual Counseling, Group Counseling, and Couples/Family Counseling), In-Home Therapy, Inpatient Psychiatric Services, and Community Based Acute Treatment Services (CBAT):

a. Participate in CANS training sponsored by EOHHS;

b. Become certified in the use of the CANS Tool and recertified every two years;

c. Use the CANS Tool whenever they deliver a Behavioral Health Clinical Assessment for a Covered Individual under the age of 21, including the initial Behavioral Health Clinical Assessment and, at a minimum, every 90 days thereafter during ongoing treatment;

d. Use the CANS Tool as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services; and

e. Subject to consent by the Covered Individual, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT system the information gathered using the CANS Tool and the determination whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance (SED);

2. The Contractor shall ensure that such Provider Contracts with Community Service Agencies require that intensive care coordinators of all levels:

a. Become certified in the use of the CANS Tool and re-certified every two years;

b. Use the CANS Tool during the comprehensive home-based assessment that is part of the initial phase of Intensive Care Coordination (ICC), at least every 90 days thereafter during ongoing care coordination, and as part of Discharge Planning from ICC services; and

c. Subject to consent by the Covered Individual, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT System the information gathered using the CANS Tool and a determination as to whether or not the Covered Individual meets the definition of an SED;

3. The Contractor shall ensure that such Provider Contracts require all Behavioral Health Providers who have clinicians who are required to provide Behavioral Health Clinical Assessments and perform the Discharge Planning process from

Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services using the CANS Tool in accordance with **Section 2.7.B**, have Virtual Gateway accounts and a high speed internet or satellite internet connection to access the CANS IT System, provided that the Contractor may have policies and procedures approved by EOHHS to grant temporary waivers for these requirements on a case by case basis;

4. The Contractor shall establish policies and procedures that:

    a. Require Behavioral Health Providers who are required to provide Behavioral Health Clinical Assessments and perform the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community Based Acute Treatment Services using the CANS Tool in accordance with **Section 2.7.C.5.a** to seek consent from the Covered Individual, parent, guardian, custodian, or other authorized individual, as applicable, before entering CANS assessments into the CANS IT System using the form of consent approved by EOHHS;

    b. Require Behavioral Health Network Providers who obtain such Covered Individual consent to enter the information gathered using the CANS Tool and the determination whether or not the assessed Covered Individual is suffering from an SED into the CANS IT System; and

    c. Require Behavioral Health Network Providers who do not obtain such Covered Individual consent to enter only the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

5. As directed by EOHHS, the Contractor shall:

    a. Pay no less than EOHHS approved rates for CPT code 90791 with modifier HA for initial Behavioral Health Clinical Assessments using the CANS Tool for Covered Individuals under the age of 21. The Contractor shall deny claims billed will ensure that any failure to include an "HA" modifier using CPT Service Code 90791 will result in a denial of the claim for members under 21, if billed without the HA modifier. For members under 21, the Contractor shall allow Network Providers up to two 90791 "HA" claims per member per site in a 90-day period. The Contractor shall also allow a new set of 90791 "HA" claims when the member experiences a lapse in service of six months or more with the original provider;

    b. Only pay a Provider for providing Behavioral Health Clinical Assessments using the CANS Tool if such Provider's servicing clinicians are certified in the CANS Tool;

c. Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments and do not bill as a separately billable service the review and updating of the assessment that is required every 90 days for Covered Individuals in ongoing, individual, group, or family therapy since such review and updating is part of treatment planning and documentation; and

d. Ensure that its Providers have the ability to access and use the CANS IT System and data contained therein, and shall, as further directed by EOHHS, participate in any testing or development processes as necessary for EOHHS to build the CANS IT System.

C. BH Inpatient and 24-hour Diversionary Services

The Contractor shall:

1. Ensure that all BH Inpatient and 24-Hour Diversionary Services Provider Contracts require the BH Inpatient and 24-Hour Diversionary Services Provider accept for admission or treatment all Covered Individuals for whom the Contractor has determined admission or treatment is Medically Necessary, regardless of clinical presentation, as long as a bed is available in an age appropriate unit;

2. Promote continuity of care for Covered Individuals who are readmitted to BH Inpatient and 24-Hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility;

3. Require BH Inpatient and 24-Hour Diversionary Services Providers to coordinate treatment and Discharge Planning with the state agencies (e.g., DCF, DMH, DYS, DDS) with which the Covered Individual has an affiliation, and that in no case shall Providers discharge patients who are homeless or who have unstable housing without a plan for housing as detailed in **Section 2.7.C.5.c.12**;

4. Ensure that all BH Inpatient and 24-Hour Diversionary Services Providers have:

   a. Human rights and restraint and seclusion protocols that are consistent with the DMH's Human Rights and Restraint Seclusion Policy and regulations and include training of the Provider's staff and education for Covered Individuals regarding human rights; and

   b. A human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to Covered Individuals Covered Individuals regarding their human rights, in accordance with applicable DMH regulations and requirements;

5. Require that BH Inpatient and 24-hour Diversionary Services Providers coordinate with designated CBHCs, including procedures to credential and grant admitting privileges to said provider psychiatrists; and

6. Convene regular meetings and conduct ad hoc communication on clinical and administrative issues with designated CBHCs to enhance the continuity of care for Covered Individuals.

D. Medication for Opioid Use Disorder (MOUD) Services

1. The Contractor shall ensure that Covered Individuals have access to MOUD Services, including initiation and continuation of MOUD, and ensure that Covered Individuals receive assistance in accessing such services.

2. The Contractor shall include in its Provider Network, qualified providers to deliver MOUD Services, by at a minimum, as further directed by EOHHS, and in accordance with all other applicable Contract requirements, offering Network Provider agreements at a reasonable rate of payment to:

   a. All Office Based Opioid Treatment (OBOT) providers as specified by EOHHS;

   b. All Opioid Treatment Program (OTP) providers as specified by EOHHS;

3. The Contractor shall ensure that all such Providers of MOUD Services coordinate and integrate care with Covered Individuals' PCPs and other providers in response to Covered Individuals' needs.

4. The Contractor shall not require an authorization or referral for MOUD Services, unless otherwise directed by EOHHS.

E. Additional Responsibilities for Certain Providers

1. At EOHHS' direction, the Contractor shall incorporate DMH's Infection Control Competencies/Standards, as set forth in Attachments A and B to DMH Licensing Bulletin 20-05R, or successor guidance, in its contracts with DMH-licensed providers of Inpatient Mental Health Services. The Contractor shall review such facility's compliance with the applicable DMH requirements as part of the Contractor's program integrity efforts pursuant to **Section 2.3.C.3**. The Contractor shall promptly report any noncompliance with the applicable DMH standards to EOHHS and shall treat such noncompliance in accordance with the Contractor's program integrity activities pursuant to **Section 2.3.C.3**.

2. As directed by EOHHS, the Contractor shall contract with the network of Community Services Agencies (CSAs) to provide Intensive Care Coordination and Family Support and Training Services. For each of these services, the Contractor shall establish Provider rates at or above the rate floor set by EOHHS in 101 CMR 352, unless otherwise directed by EOHHS, and shall, as directed by EOHHS, use the procedure codes specified by EOHHS to provide payment for such services.

3. As directed by EOHHS, the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 352, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for the following services:

   a. Family Support and Training Services;

   b. In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services; and

   c. In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support).

F. Provider Payments

The Contractor's payments to Network Providers shall be consistent with the provisions of this Section:

1. Timely Payment to Providers

   The Contractor shall make payment on a timely basis to Providers for BH Covered Services furnished to Covered Individuals, in accordance with 42 USC 1396u-2(f) and 42 CFR 447.46. Unless otherwise provided for and mutually agreed to in a contract between the Contractor and a Provider that has been reviewed and approved by EOHHS, the Contractor shall:

   a. Pay 90% of all Clean Claims for BH Covered Services from Providers within 30 days from the date the Contractor receives the Clean Claim;

   b. Pay 99% of all Clean Claims from Providers within 60 days from the date the Contractor receives the Clean Claim;

   c. Submit a Claims Processing annual report in accordance with **Appendix E-1**; and

   d. For the purposes of this Section, the day the Contractor receives the Clean Claim is the date indicated by the date stamp on the claim and the day the Contractor pays the Clean Claim is the date of the check or other form of payment.

   e. Not require a Network Provider to pay a claims processing fee.

2. The Contractor shall not implement any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay or limit specific, Medically Necessary Services.

   a. The Provider shall not profit from provision of BH Covered Services that are not Medically Necessary or medically appropriate.

b. The Contractor shall not profit from denial or withholding of BH Covered Services that are Medically Necessary or medically appropriate.

c. Nothing in this Section shall be construed to prohibit Contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Covered Individuals if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider.

3. Minimum payment rates for Certain Behavioral Health Services

a. The Contractor shall provide specialized inpatient psychiatric services to Covered Individuals under the age of 21 with Autism Spectrum Disorder-Intellectual Disability (ASD-ID) in specialized ASD-ID inpatient psychiatric treatment settings, as directed by EOHHS:

1) The Contractor shall report claims paid for psychiatric Inpatient Services delivered to Covered Individuals under the age of 21 in specialized ASD-ID inpatient psychiatric treatment settings to EOHHS in a form and format and at a frequency to be determined by EOHHS;

2) The Contractor shall pay Providers no less than the rate specified by EOHHS for inpatient psychiatric services delivered to Covered Individuals under the age of 21 with ASD-ID in specialized ASD-ID inpatient psychiatric treatment settings, and shall use procedure codes as directed by EOHHS to provide payment for such services;

b. For Case Consultation, Family Consultation, and Collateral Contact services delivered to Covered Individuals under the age of 21, the Contractor shall:

1) Establish a 15-minute rate at or above one quarter of the 60 minute rate the Contractor sets for providers for outpatient Individual Treatment, or the amount set forth in **Appendix L**, whichever is higher, and shall use procedure codes as directed by EOHHS to provide payment for such services.

c. For Acute Treatment Services for Substance Use Disorders (Level 3.7), including Individualized Treatment Services, the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

d. For Clinical Support Services for Substance Use Disorders (Level 3.5), including Individualized Treatment Services, the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

e. For Applied Behavioral Analysis (ABA Services), the Contractor shall establish provider rates at or above the rate floor set by EOHHS in 101 CMR 358.00, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

f. For all Residential Rehabilitation Services for Substance Use Disorder (Level 3.1), described in **Appendix A-1** the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

g. For Population-Specific High Intensity Residential Services (ASAM Level 3.3.), the Contractor shall establish provider rates at or above the rate floor as specified by EOHHS, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

h. For Program of Assertive Community Treatment services (PACT), the Contractor shall establish provider rates at or above the rate floor as specified in 101 CMR 430.03, and shall use procedure codes as directed by EOHHS to provide payment for such services.

i. Effective April 1, 2023, for inpatient substance use disorder services provided by freestanding substance use disorder hospitals, the Contractor shall establish provider rates at or above the rates under Appendix A of the MassHealth Program Provider Agreement: Special Conditions for Substance Abuse Treatment Hospitals, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

j. For Structured Outpatient Addiction Program Services and Enhanced Structured Outpatient Addiction Program Services, the Contractor shall establish provider rates at or above the rate floor as set by EOHHS in 101 CMR 306, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

k. For Opioid Treatment Program services, the Contractor shall establish provider rates at or above the rate floor, set by EOHHS in 101 CMR 444,

unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

l. The Contractor's payment rates to inpatient psychiatric hospitals for Covered Individuals placed on AND status shall be adequate to maintain the ongoing provision of appropriate clinical care until date of discharge.

m. For inpatient mental health services, the Contractor shall establish provider rates at or above the rates under Section 5.B.4 of the MassHealth Acute Hospital Request for Application and Section 4.2 of Attachment A to the MassHealth Psychiatric Hospital Request for Application, unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

n. The Contractor shall:

1) In accordance with **Section 2.7.F.3.J.2.** increase its payment rates to in-state acute hospitals for:

a) adjudicated inpatient discharge by a uniform dollar amount specified by EOHHS; and

b) adjudicated outpatient episodes by a uniform dollar amount specified by EOHHS.

2) The increased payment rates shall be a uniform dollar amount through lump sum payments as directed by EOHHS and consistent with the uniform dollar amount increase payment methodology set forth in the MassHealth Acute Hospital RFA. If directed by EOHHS, the Contractor shall pay in-state acute hospitals an additional uniform dollar amount based on the reconciliation set forth in **Section 4.5** by a date specified by EOHHS.

o. For CBHI Services other than YMCI, the Contractor shall establish Network Provider rates at or above the rate floor specified in 101 CMR 352.00 and procedure codes as set forth in **Section 2.7.K.3**, unless otherwise directed by EOHHS.

p. For YMCI Services, the Contractor shall establish Network Provider rates for CBHCs at or above the rates specified in 101 CMR 305.00 unless otherwise directed by EOHHS, and shall use procedure codes as directed by EOHHS to provide payment for such services.

4. Behavioral Health Quality Incentive Payment

The Contractor shall:

a. For each Contract Year, collect the following information, in a form and format and at times specified by EOHHS, from all non-federal, non-state

public hospitals in the Contractor's Network:

1) At the time of the midpoint evaluation specified by EOHHS:

a) Progress on certain behavioral health quality measures and related performance goals specified by EOHHS; and

b) Additional information as specified by EOHHS.

2) At the time of the year end evaluation specified by EOHHS:

a) Performance information on certain behavioral health quality measures specified by EOHHS; and

b) Additional information as specified by EOHHS.

b. Submit to EOHH, at a time and in a manner specified by EOHHS:

1) The information the Contractor collected in accordance with **Section 2.7.F.4** above; and

2) A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

c. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments specified by EOHHS, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to such non-federal, non-state public hospitals. The Contractor shall make such payments to such providers within 3 business days of receiving payment from EOHHS.

5. Clinical Quality Incentive for Acute Hospitals

The Contractor shall:

a. For each Contract Year, collect the following information, in a form and format and at times specified by EOHHS, from acute care hospitals that have executed the MassHealth Acute Care Hospital RFA (RFA):

1) At the time of the midpoint evaluation specified by EOHHS:

a) Progress on certain measures targeting clinical quality and related performance goals specified by EOHHS; and

b) Additional information as specified by EOHHS.

2) At the time of year end evaluation specified by EOHHS:

a) Performance information on measures targeting clinical quality specified by EOHHS; and

b) Additional information as specified by EOHHS.

b. Submit to EOHHS, at a time and manner specified by EOHHS:

1) The information the Contractor collected in accordance with **Section 2.7.F.5** above; and

2) A certification notifying EOHHS that, to the Contractor's knowledge, such information is accurate and complete.

c. In return for such Providers providing the Contractor with accurate and complete information specified above, make value-based payments at a frequency specified by EOHHS, pursuant to 42 CFR 438.6(c) and as specified by EOHHS, to acute care hospitals that have executed the RFA. The Contractor shall make such payments to such providers within 14 calendar days of receiving payment from EOHHS.

6. Value-Based Payment (VBP)

a. The Contractor shall develop for EOHHS review and shall implement a multi-year VBP strategy with its Behavioral Health Network Providers focused on increasing its use of VBP methodologies aimed at meaningfully incentivizing providers to improve performance, resulting in enhanced experience of care for Covered Individuals and improved outcomes.

b. The Contractor shall implement a Pay for Reporting (HCP-LAN Category 2B) methodology during CY2023 to support provider reporting of identified Behavioral Health performance measures, including but not limited to performance measures that EOHHS requires the Contractor to report. At a minimum, the Contractor shall establish these Pay For Reporting contracts in CY2023 with CBHCs and high-volume ATS and CSS treatment providers.

c. The Contractor shall utilize initial performance measure reporting results from providers received in CY2023 to identify benchmarks for specific measures to implement Pay for Performance (HCP-LAN Category 2C) as part of its provider contracts during CY2024.

d. The Contractor shall also encourage Behavioral Health providers to participate in VBP methodologies in which providers have the opportunity to share in savings based on improving health care quality and reducing costs. The Contractor shall work towards having an increasing amount of its provider contracts in a VBP model that falls within the HCP-LAN Category 3 or 4 models. At EOHHS' direction, Contractor shall implement specific VBP models.

e. The Contractor shall report on its progress in implementing VBP models with Network Providers on an annual basis, including reporting on

numbers and types of providers with which the Contractor has entered into a VBP arrangement, the types of VBP models used according to the HCP-LAN APM Framework and how the Contractor has facilitated providers' ability to successfully meet VBP requirements including with timely, actionable data and other tools to support care delivery.

G. Provider Directory and Other Information

1. The Contractor shall maintain a BH Provider directory (or directories) as further specified by EOHHS. Such directory (or directories) shall include Behavioral Health Providers, hospitals, specialists, sub-specialists, and ancillary service Providers, including a listing of statewide emergency rooms and CBHCs, that is made available in Prevalent Languages and Alternative Formats, upon request, and includes, at a minimum, the following information:

    a. Alphabetical Provider list, including any specialty and group affiliation as appropriate;

    b. Geographic list of Providers by town;

    c. Office address and telephone numbers for each Provider, as well as website URL as appropriate;

    d. Office hours for each Provider;

    e. The Provider's Cultural and Linguistic Competence and capabilities, including languages spoken by Provider or by skilled medical interpreter at site, including ASL, and whether the Provider has completed cultural competence training;

    f. Whether or not the Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment;

    g. Qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use); and

    h. For ancillary services Providers: 1) Alphabetical Provider list; and 2) Geographic list of Providers by town.

2. The Contractor shall provide EOHHS with an updated electronic submission of its Provider directory (or directories) on a semi-annual basis, if updated, and an electronic submission of changes to the Provider Network monthly.

3. The Contractor shall provide the Provider directory to its Covered Individuals as follows:

    a. The Contractor shall provide a copy in paper form to Covered Individuals upon request. The Contractor shall update its paper-version of its Provider

directory monthly if the Contractor does not have a mobile-enabled, electronic directory as further specified by EOHHS and quarterly if the Contractor has such mobile-enabled electronic directory as further specified by EOHHS;

b. The Contractor shall include written and oral offers of such Provider directory in its outreach and orientation sessions for New Covered Individuals; and

c. The Contractor shall include an electronic copy of its Provider directory on the Contractor's website in a machine-readable file and format. The Contractor shall update its electronic version of its Provider directory no later than 30 calendar days after being made aware of any change in information.

4. As requested by EOHHS, the Contractor shall, in a form and format specified by EOHHS, report to EOHHS its Network Providers and whether each provider is enrolled as a MassHealth provider;

5. The Contractor shall develop, maintain and update information about Behavioral Health Providers with areas of special experience, skills, and training including, but not limited to, Providers with expertise in treating: children, adolescents, people with HIV, homeless persons, people with disabilities, people with Autism Spectrum Disorder, people with early psychosis, people who are deaf or hard-of hearing, people who are blind or visually impaired, and children in the care or custody of DCF or youth affiliated with DYS (either detained or committed). The Contractor shall make available to EOHHS and Covered Individuals such information upon request.

6. The Contractor shall provide to a Covered Individual directly, or through referral, publicly available information maintained by the Massachusetts Board of Registration in Medicine (BORIM) and the National Practitioner Databank on the malpractice history of any Provider(s), upon a Covered Individual's request;

7. The Contractor shall demonstrate to EOHHS, by reporting annually in accordance with **Appendix E-1**, that all Providers within the Contractor's Provider Network are credentialed according to **Section 2.8.G**. of the Contract;

8. Provider Network Changes

a. The Contractor shall provide notice to EOHHS of significant changes (additions or deletions) in the operations of the Provider Network and significant to the Provider Network itself, that will affect the adequacy and capacity of services. At the time of any change that (a) prevents the Contractor from complying with **Sections 2.7.A. and B**; or (b) is considered significant pursuant to **Section 2.8.H.8.b** below, the Contractor shall provide immediate written notice to EOHHS, with the goal of

providing notice to EOHHS at least 60 days prior to the effective date of any such change. Such notice shall be in the form and format specified by EOHHS and the Contractor shall provide EOHHS will all requested information about the significant change;

b. Significant changes requiring notification include, but are not limited to, the following:

1) Changes in the operations of the Provider Network that result from EOHHS changes in BH Covered Services, and Provider or Material Subcontractor payment methodology;

2) Enrollment of a new population in the Contractor's Plan;

3) Any termination or non-renewal of a hospital, community health center or community mental health center contract;

4) Any termination or non- renewal of a Behavioral Health Provider or specialist contract that results in there being no other, or a limited number of, Behavioral Health Providers or specialists available in a particular part of the Region; or

5) Any termination or non-renewal of a Behavioral Health Provider or specialist contract that results in there being no other, or a limited number of Behavioral Health Providers or specialists available within a service area.

c. The Contractor shall provide any information requested by EOHHS pertaining to any such significant change within seven calendar days of the request;

d. For Behavioral Health Provider Network significant changes, the Contractor shall notify EOHHS of the number of affected Covered Individuals, and the specific steps the Contractor is taking to assure that such Covered Individuals continue to have access to Medically Necessary Services;

e. The Contractor shall provide to EOHHS a written summary of all significant change(s) with its next Annual Summary of Access and Availability report set forth in **Appendix E-1**, and in the timeframes specified in **Appendix E-1**, that describes the issues, the steps taken to date to assure that Covered Individuals have access to Medically Necessary services, and any relevant next steps; and

f. In the event that a Provider leaves or is terminated from the Contractor's Network, the Contractor shall follow the process set forth by EOHHS for communicating with and, as appropriate, transitioning Covered Individuals affected by the termination. Such process shall include

developing a member communication and outreach plan and a provider communication and outreach plan, and performing other activities EOHHS determines necessary;

H. Community Behavioral Health Center (CBHC) Program

1. CBHC Implementation and Operations

The Contractor shall, as directed by EOHHS, take all steps and perform all activities necessary to support the successful implementation and ongoing operations of the CBHC program, which shall include, without limitation, participation in meetings and workgroups, including joint workgroups with all MassHealth-contracted managed care entities to develop coordinated network management and quality improvement strategies for all payers and other tasks as directed.

2. Contracting with CBHCs

The Contractor shall execute and maintain contracts with CBHCs identified in **Appendix A-3** and pay CBHCs no less than the payment rates established by EOHHS in 101 CMR 305.000 and shall use procedure codes as directed by EOHHS to provide payment for services rendered by CBHCs.

3. CBHC Service Authorization

The Contractor shall not require prior authorization for any services provided under the CBHC program.

4. Management of CBHC Network

The Contractor shall:

a. Ensure that CBHCs provide services in accordance with all EOHHS-approved performance specifications and Medical Necessity criteria.

b. Ensure that appropriate members of the CBHCs' staff participate in CBHC training, coaching, and mentoring as approved by EOHHS for CBHC training. The Contractor shall ensure that such members of CBHCs' staffs utilize evidence-based practice in service delivery.

c. Develop operational manuals for selected CBHC services, including but not limited to AMCI and YMCI.

d. Perform quality assurance and training activities for CBHCs as directed by EOHHS.

e. Work collaboratively with all MassHealth payers to manage the network of all CBHCs by:

1) Coordinating regional and statewide meetings for all CBHC components that include all MassHealth-contracted payers, at a frequency agreed to annually by EOHHS. The Contractor shall coordinate and pay for administrative costs associated with such meetings; and

2) Coordinating with all MassHealth-contracted payers to provide joint technical assistance and network management to specific CBHC providers as necessary to address quality improvement and ensure full program implementation, and to monitor ongoing program operations and outcomes.

f. Assign a point of contact for management for each CBHC to provide technical assistance to CBHCs as needed and to monitor individual CBHC performance.

g. Require CBHCs to track and report monthly to the Contractor on each component service. The reported data shall include information for all MassHealth Members using these services, regardless of the member's managed care enrollment.

h. In collaboration with, and as further directed by EOHHS, develop a plan to ensure the quality of CBHC component services, including but not limited to access and availability.

i. In Contract Year 2023, at the direction of EOHHS, execute a public service campaign to increase public awareness of the AMCI, YMCI services and CBHCs.

5. CBHC Policies and Procedures

For CBHC providers under contract with the Contractor, the Contractor shall:

a. Ensure that CBHCs provide Covered Individuals with unrestricted statewide access, and that Uninsured Individuals and persons covered by Medicare only are provided with unrestricted state-wide access to AMCI and YMIC services immediately in response to a Behavioral Health crisis, on a 24-hour basis, seven days a week;

b. Ensure that all CBHC providers set forth in **Appendix A-3** provide all components of the CBHC program in accordance with the Contract and in a manner that is consistent with the Contractor's performance specifications and maximizes utilization of community-based diversion strategies.

c. The Contractor shall require CBHCs to implement the CBHC program to meet EOHHS' vision, including providing readily available outpatient Behavioral Health evaluation and treatment in community-based locations.

d. Ensure that CBHC services are available on site at all community-based locations for minimum of 12 hours per day on weekdays and 8 hours per day on weekends;

e. Ensure that the response time for face-to-face community crisis evaluations does not exceed one hour from notification of the need, or, in the case of referrals from hospital emergency departments, does not exceed the time set forth in the applicable agreement between the CBHC and the hospital, as approved by EOHHS;

f. Ensure that CBHCs provide Covered Individuals with 24-hour-a-day access to clinicians who have special training or experience in providing Behavioral Health services for:

1) the full array of Behavioral Health conditions;

2) children and adolescents (clinicians providing Youth CI must be child-trained clinicians who meet competency standards as defined in the Contractor's performance specifications);

3) individuals with substance use conditions or a Dual Diagnosis;

4) individuals with intellectual disabilities, developmental disabilities, or autism spectrum disorders; and

5) older adults;

g. Ensure that CBHCs include Recovery Coaches as part of their team to provide non-judgmental, non-clinical recovery support to individuals in a SUD crisis.

h. At the direction of EOHHS, identify and implement strategies to maximize utilization of community-based diversion services and reduce unnecessary psychiatric hospitalization, in a manner that is consistent with medical necessity criteria. Such strategies shall support providers in shifting the volume from hospital EDs to community-based settings.

i. Establish policies and procedures to ensure that all Covered Individuals receive AMCI or YMCI provided by a CBHC or a crisis evaluation provided at a hospital prior to hospital admissions for Inpatient Mental Health Services to ensure that the Covered Individuals have been evaluated for diversion or referral to the least restrictive appropriate treatment setting. The Contractor's policies and procedures shall:

1) Require that the CBHC located in the geographic area where the individual is physically located perform the AMCI or YMCI;

2) Not require prior authorization to provide a Crisis Intervention and Assessment;

3) Develop contract standards, reviewed and approved by EOHHS annually, and monitor CBHCs' performance to minimum standards and goals for diversionary rates on:

a) providing same day treatment for Urgent Care,

b) expanded weekend and evening hours,

c) diversion and inpatient admission rates,

d) timeliness of assessment, and

e) rate of community-based AMCI or YMCI

4) Authorize Medically Necessary BH Covered Services within 24 hours following a AMCI or YMCI encounter.

j. Require and ensure that CBHCs have arrangements, agreements or procedures to coordinate care with Network Providers, MassHealth managed care entities, DMH area and site offices, DCF regional offices, and DYS regional offices in the geographic area they serve;

k. Require and ensure that CBHCs make all reasonable attempts to work with local police and EMS to develop models of mutual response to Behavioral Health Emergencies maximizing the value of the 24/7 community based locations when needed. These models may include the delivery of services via telehealth when clinically appropriate.

l. Collaborate with EOHHS regarding CBHC network management and CBHC policy development, including participation in meetings and workgroups, the development and implementation of new policies, and any other tasks as directed by EOHHS.

m. Develop targeted performance measures for CBHCs as approved by EOHHS. Using these performance measures, the Contractor shall develop a baseline performance level for each CBHC provider, and regularly track performance.

6. CBHC Administrative Oversight

The Contractor shall coordinate the administration and management of the CBHCs as specified in this Contract and as further directed by EOHHS. In this role, the Contractor shall:

a. Facilitate at least six (6) statewide meetings each Contract Year, or otherwise as directed by EOHHS, with contracted CBHCs, and invite the participation of MassHealth managed care plans, to support consistency in service delivery;

b. Require CBHCs to refer adult Uninsured Individuals and persons with Medicare only to available beds in psychiatric units of general hospitals first, if beds in such hospitals are available and clinically appropriate, before referring them to psychiatric hospitals;

c. After a court clinician has conducted a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e), ensure that upon request of such court clinician:

1) CBHCs provide AMCI and YMCI to all Covered Individuals (including onsite mobile evaluations at the court);

2) Identify to the court clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions. Nothing in this provision shall be construed as establishing a court clinician evaluation as a prerequisite to an onsite mobile evaluation at the court; and

3) If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), CBHCs conduct a search for an available bed, making best efforts to locate such a bed for the individual by 4:00 p.m. on the day of the issuance of such commitment order. If a bed is not found by 4:00, the CBHC will work with the court clinician to ensure appropriate disposition and transfer of the individual to a safe place outside of the court setting.

d. Adopt the existing Massachusetts Behavioral Health Access System, or adopt such other system as directed by EOHHS, that helps CBHCs and hospital EDs to search on-line for available Inpatient Mental Health Services, Inpatient Substance Abuse Services, 24-hour Diversionary Services and CBHI Services.

1) The system shall provide on-line web access on a 24-hour basis, seven days per week.

2) The Contractor shall ensure that the web-based system is updated at least once every eight hours for 24-hour services, and at least weekly for CBHI Services (Intensive Care Coordination, In-Home Behavioral Services, Therapeutic Mentoring, In-Home Therapy).

3) The Contractor shall develop an annual report (with specifications subject to EOHHS review and prior approval) that tracks utilization of the Massachusetts Behavioral Health Access System and other data as agreed to by the parties.

7. Monitoring CBHC Performance

The Contractor shall:

a. Have policies and procedures to monitor the CBHC's performance with respect to established diversion and inpatient admission rates;

b. Have policies and procedures to monitor the CBHC's performance with respect to diverting encounters with Covered Individuals from hospital EDs to the CBHC's community-based location or other community settings;

c. Have policies and procedures regarding the circumstances under which CBHCs shall contact the Contractor for assistance in securing an inpatient or 24-Hour Diversionary Service placement. Such policies and procedures shall include that if a CBHC requests the Contractor's assistance in locating a facility that has the capacity to timely admit the Covered Individual, the Contractor shall contact Network Providers to identify such a facility or, if no appropriate Network Provider has such capacity, shall contact out-of-network Providers to identify such a facility;

d. Have policies and procedures to ensure collaboration between YMCI teams, Community Service Agencies (CSAs), and other youth serving Providers;

e. Have a plan in place to direct Covered Individuals to the least intensive but clinically appropriate service;

f. Have a process to ensure placement for Covered Individuals who require Behavioral Health Inpatient Services when no inpatient beds are available, as described in **Section 2.5.K**;

g. Utilize standardized documents such as risk management/safety plans as identified by EOHHS;

h. Convene meetings to address clinical and administrative issues with CBHCs and to enhance the coordination of care for Covered Individuals;

i. Convene meetings with MassHealth MCOs, ACOs, and EOHHS and CBHCs, as directed by EOHHS;

8. Encounter Forms

The Contractor shall:

a. Create and implement an EOHHS-approved electronic CBHC Encounter form to report on Services provided by CBHCs described in **Appendix A-1**;

b. Require CBHCs to complete and submit the electronic EOHHS-approved CBHC Encounter form for each individual they serve;

c. Work with EOHHS to develop CBHC reporting metrics consistent with the CBHC Encounter data; and

d. Develop reporting procedures, approved by EOHHS, to include but not limited to the following:

1) Monthly CBHC Dashboard including all component services;

2) Monthly network management meeting list; and

3) Standard process for reporting quality issues to EOHHS, including notification of any CBHC provider on a corrective action.

9. Use of Technology

The Contractor shall require CBHC providers to adopt technology to support community-based diversion including:

a. Technology that supports decentralized staffing models and remote dispatch;

b. HIPAA compliant two-way interactive audio-video for services provided via telehealth (e.g., phone, tablet, video conferencing); and

c. Call center technology that includes real-time data dashboard to track staff availability, staff dispatch, stage of crisis, CCS bed census, detail about referral sources, and other metrics as determined by EOHHS.

I. Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP)

1. The Contractor shall ensure that its contracted CBHCs establish a "Mobile Crisis Intervention/Runaway Assistance Program" (MCI/RAP). Through this program, as further described in this **Section 2.7.I**, the CBHCs shall provide a temporary and safe place for Youth as defined in **Section 2.7.I.2** below to stay on a voluntary basis, until such Youth is transferred to an Alternative Lock-up Program or other appropriate level of service.

2. For the purposes of the MCI/RAP, the following definitions shall apply:

a. Youth –

1) Any "Child Requiring Assistance"' under Chapter 240 of the Acts of 2012, currently defined as a child between the ages of 6 and 18 who: (i) repeatedly runs away from the home of the child's parent, legal guardian or custodian; (ii) repeatedly fails to obey the lawful and reasonable commands of the child's parent, legal guardian or custodian, thereby interfering with their ability to adequately care for and protect the child; (iii) repeatedly fails to obey the lawful and reasonable regulations of the child's school; (iv) is habitually truant; or (v) is a sexually exploited child; or

2) Any minor between the ages of 7 and 18 who has been arrested by police for a non-violent offense.

b. MCI/RAP site – the site the CBHC maintains to operate the MCI/RAP.

c. Non-Court Hours – Hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically Monday through Friday between 4:30 PM and 8:30 AM, weekends, and holidays.

d. Alternative to Lock-up Program – See definition in **Section 1.1**.

3. Implementation of MCI/RAP

In implementing the MCI/RAP, the Contractor shall require its contracted CBHCs to:

a. Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.

b. Maintain an MCI/RAP site where police can bring Youth during Non-Court Hours.

c. Greet police officers and Youth who come to the MCI/RAP site during Non-Court Hours.

d. Supervise Youth brought by a police officer to the MCI/RAP site on at least a one-to-one basis until the Youth:

1) Is transferred to a hospital level of care;

2) Is transferred to the care of Alternative Lock-up Program (ALP) staff; or

3) Voluntarily leaves the site.

e. If a Youth who was brought to the MCI/RAP site chooses to voluntarily leave the site,

1) Immediately notify the police department of the city or town where the MCI/RAP site is located and the Department of Children and Families (DCF) (if the Youth is known to be in DCF custody), of the youth's departure,

2) Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123, §12, and, if determined appropriate, apply for hospitalization of such Youth; and

3) Submit a critical incident report form to the Contractor. The Contractor shall submit such report to EOHHS.

f. Designate a manager to oversee the MCI/RAP. The manager shall:

1) Ensure MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court Hours and be available to MCI/RAP staff for consultation;

2) Provide back-up coverage for on-call MCI/RAP staff;

3) Train program staff regarding MCI/RAP procedures;

4) Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP; and

5) On the following business day, follow up with the police department that transported the Youth to the MCI//RAP site, and follow-up with any ALP to which the Youth was transferred.

4. MCI/RAP Outreach and Training

As directed by EOHHS, the Contractor shall provide additional outreach and training to contracted CBHCs and other stakeholders, including:

a. Meeting with the CBHCs, police and probation officers, and ALPs to discuss the MCI/RAP;

b. In conjunction with EOHHS and its designees (such as Mass211), hosting statewide trainings or conferences, in addition to requirements outlined in **Section 2.14** of this Contract; and,

c. Training Contractor staff on MCI/RAP.

5. MCI/RAP Outcome and Output Measures

The Contractor shall require its contracted CBHCs to provide quarterly and annual reports to the Contractor, who will report to EOHHS, in a form and format agreed upon by the Contractor and EOHHS, on outcomes and outputs related to the MCI/RAP, including but not limited to:

a. The number of Youth who receive a crisis intervention assessment;

b. Demographics related to Youth served including but not limited to age, gender, ethnicity and city/town of residence

c. The number of Youth unable to be maintained safely at the MCI/RAP site and require further assessment in the secure environment of the emergency department;

d. The number of Youth transferred to the care of Alternative Lock-up Program (ALP) staff; and

e. The number of Youth who voluntarily leave the MCI/RAP site.

J. Children's Behavioral Health Initiative (CBHI)

1. CBHI Training and Quality Improvement

a. The Contractor shall, as directed by EOHHS, take all steps and perform all activities necessary to improve the CBHI, which shall include, without limitation, participation in meetings and workgroups, including joint workgroups with all MassHealth Managed Care payers to develop coordinated network management and quality improvement strategies for all payers on these services and other tasks as directed.

2. Use of the CANS Tool

The Contractor shall ensure the continued use of the CANS Tool by all Behavioral Health Service providers that are required to use it (see **Section 2.7.B**), as directed by EOHHS. The Contractor shall:

a. Pay EOHHS approved rates for initial Behavioral Health Clinical Assessments using the CANS Tool for Covered Individuals under the age of 21 as described in **Section 2.7.B.5.a**;

b. Ensure that it pays only Network Providers whose servicing clinicians are certified in the CANS Tool for providing Behavioral Health Clinical Assessments using the CANS Tool;

c. Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments. The review and updating of the CANS assessment that is required at a minimum every 90 days for Covered Individuals in ongoing individual, group, or family therapy is part of the treatment planning and documentation, and as such, is not a separately billable service.

d. Ensure that its customer services representatives who respond to questions from Network Providers are informed about the requirements and process for applicable Network Providers to become trained and certified in administering the CANS Tool and can respond to questions from Network Providers about these requirements and processes. The Contractor shall provide training to its newly hired and existing customer services representatives about when, where and how Network Providers obtain CANS training and certification, and shall provide refresher trainings as directed by EOHHS and as the Contractor determines is necessary.

e. Ensure that its customer services representatives who are assigned to respond to inquiries from Covered Individuals are informed about the use of the CANS and other CBHI Services, and can respond to Covered Individuals' questions about them. The Contractor shall provide training to

its newly hired and existing customer services representatives about the CANS Tool and how it is generally used in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services, and Transitional Care Units.

f. As directed by EOHHS, ensure that Covered Individual materials, including but not limited to the Handbook for Covered Individuals, describe the CANS Tool and its use in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services for Covered Individuals under the age of 21.

g. As directed by EOHHS, ensure that appropriate Network Provider materials exist to describe the CANS Tool, the requirements and process for CANS Tool training and certification, and the CANS IT System.

h. Be able to access and use the CANS IT System and data contained therein to integrate with clinical data, and use in reporting as directed by EOHHS.

i. Participate in any testing or development processes necessary for EOHHS to develop and refine the CANS IT System.

3. CBHI Procedure Codes

The Contractor shall use procedure codes as directed by EOHHS to provide payment for CBHI services.

4. CBHI Service Authorization

a. The Contractor shall inform EOHHS in writing of its authorization procedures for Behavioral Health Covered Services for Covered Individuals under 21 who are receiving CBHI Services, and of any changes to such authorization procedures prior to their implementation. The Contractor shall assist Network Providers in learning how to utilize Contractor's authorization procedures for CBHI Services. The Contractor shall monitor its authorization procedures to ensure that the procedures provide for timely access to services. In the event that the Contractor's authorization procedures for CBHI Services result in delays or Barriers to accessing Medically Necessary BH Covered Services, the Contractor shall modify such authorization procedures. The Contractor shall coordinate with other MassHealth payers to publish a single document that describes the authorization procedures for all MassHealth payers for these services.

b. The Contractor shall ensure that the authorization procedures established for Intensive Care Coordination (ICC) and Family Support and Training (FS and T) allow for at least the first 28 days of services to be provided without prior approval. The Contractor may establish notification or registration procedures during the first 28 days of ICC.

c. The Contractor shall ensure that its authorization procedures comply with all provisions of **Section 2.6.C** of the Contract and, in addition, that all authorization approvals for ICC and FS and T are provided telephonically or electronically.

5. Management of CBHI Service Provision

The Contractor shall:

a. Ensure that Network Providers of CBHI Services provide each such service in accordance with all EOHHS-approved CBHI Services Performance Specifications and CBHI Services Medical Necessity criteria.

b. Ensure that appropriate members of Providers' staffs participate in CBHI training, coaching, and mentoring as approved by EOHHS for CBHI training. The Contractor shall ensure that such members of Providers' staffs complete CBHI training, and utilize their new skills in service delivery. If the Provider is not participating in CBHI training, the Contractor shall engage in Provider Network management activities to increase training.

c. Maintain operational manuals for selected CBHI services, including but not limited to Youth Mobile Crisis Intervention.

d. Perform quality assurance and training activities for CBHI services as directed by EOHHS. These activities shall include providers within the networks of MassHealth Managed Care entities who provide CBHI Services.

e. Work collaboratively with all MassHealth payers to manage the network of all CBHI Service providers, including the Community Service Agencies (CSAs) that provide ICC and Family Support and Training, as well as the providers of In-Home Therapy, In-Home Behavioral Services and Therapeutic Mentoring, by:

1) Coordinating regional and statewide meetings for all CBHI service types that include all MassHealth payers, at a frequency agreed to annually by EOHHS. Contractor is responsible for coordination and administrative costs associated with such meetings; and

2) Coordinating with all MassHealth payers to provide joint technical assistance and network management to all contracted CBHI

providers as necessary to address quality improvement and ensure full program implementation.

f. Manage the existing Community Service Agencies that are contracted to deliver ICC and Family Support and Training services. Any changes to the CSA network must be approved in advance by EOHHS.

g. Maintain, revising as necessary and submitting to EOHHS for approval whenever revised, the Intensive Care Coordination and Family Support and Training Operations Manual (ICC Ops Manual). The Contractor shall ensure that the ICC Ops Manual conforms to the EOHHS-approved performance specifications for ICC and Family Support and Training. The Contractor shall distribute the EOHHS-approved ICC Ops Manual to all CSAs in the Network.

h. Ensure that CSAs provide ICC and Family Support and Training services according to both the EOHHS-approved performance specifications and the EOHHS-approved ICC Ops Manual. In the event that there are discrepancies between the two documents, the performance specifications shall control and the Contractor shall notify EOHHS of any discrepancies and submit a correction for EOHHS approval.

i. Assign a point of contact for management for each CSA and identify such individual to EOHHS prior to the Operational Start Date. Responsibilities shall include, but are not limited to, providing technical assistance to CSAs to answer questions regarding authorization of services and assisting CSAs in facilitating and ensuring that Network Providers engaged in a Covered Individual's treatment participate in ICC Individual Care Plan Team (CPT) meetings.

j. Require CSAs to track and report monthly to the Contractor on ICCs and referrals to ICC services according to the template provided in the ICC Ops Manual. The reported data shall include information for all MassHealth Members using these services, regardless of the Member's managed care enrollment.

k. Require CSAs to provide the Contractor with EOHHS-required data for a particular month in sufficient time to submit such reports to EOHHS by the 30th of the following month (or by the next business day after the 30th if the 30th falls on a weekend day).

l. Ensure that each CSA coordinates and maintains a local Systems of Care committee to support the CSA's efforts to establish and sustain collaborative partnerships among families and community stakeholders in its geographic area. The Contractor shall assign a staff person to oversee

the local Systems of Care committees; the staff person's responsibilities shall include but are not limited to:

1) attending meetings of the Systems of Care committees on a quarterly basis;

2) monitoring System of Care committees' activities and issues on a monthly basis through review of meeting minutes; and

3) conducting network management meetings with the CSAs.

m. In collaboration with, and as further directed by EOHHS, develop a plan to ensure that the quality of ICC and Family Support and Training services is measured using tools that are consistent with national Wraparound standards, such as the Wraparound Fidelity Index tool and the Team Observation measure ("fidelity tools"), and provide CSAs with such fidelity tools at no cost to the CSAs. In addition, use tools such as the MA DRM (Document Review Measure) to review medical files in both ICC and In Home Therapy.

n. In collaboration with and as further directed by EOHHS, develop a process to monitor the quality of services using tools such as the MA DRM or another tool approved by EOHHS to evaluate the adequacy of medical record keeping for both ICC and In-Home Therapy Services (IHT). The Contractor shall apply the approved quality-assessing tool at least annually on a mix of ICC and IHT services provided across all of the Contractor's regions. Unless otherwise directed by EOHHS, the Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Covered Individuals who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 10 Covered Individuals medical files per region per Contract Year.

6. CBHI Access Reporting

The Contractor shall ensure that the web-based Behavioral Health Access System or the Contractor's equivalent system, as referenced in **Section 2.7.H.6.d** above, is updated at least once a week for CBHI Services (ICC, IHBS, TM and IHT) to show access and availability.

a. CBHI Service reporting must be available to the public on the system.

b. CBHI access and availability reports must be reported monthly from this system.

K. Restoration Center

The Contractor shall make available Restoration Center services to Covered Individuals as further directed by EOHHS. The Contractor shall:

1. Execute and maintain contracts with Restoration Center providers;

2. Pay for BH Covered Services rendered at Restoration Centers to Covered Individuals; and

3. Take all steps and perform all activities necessary to maintain contracts with Restoration Centers, including, without limitation, participation in meetings and workgroups, the development and implementation of new policies, and any other tasks as further directed by EOHHS.

L. Special Service Initiatives

1. During the term of the Contract, the Contractor shall propose for EOHHS's review and approval special new services and programs for Covered Individuals for which the Contractor may need to adapt its Provider Network. The Contractor shall perform a cost-benefit analysis for any new service it proposes to develop, as directed by EOHHS, including whether the proposed services would have an impact on Base PMPM Capitation Rates or the Administrative Component of the MassHealth Capitation Payment. The Contractor shall implement new special services and programs as approved by EOHHS.

2. As directed by EOHHS, the Contractor shall support the ongoing development and implementation of structural reforms to the clinical design and delivery of clinic-based outpatient Behavioral Health and CBHC services with the goals of achieving integrated care for mental health and addiction, open access to Behavioral Health Urgent Care inclusive of prescribing, and improved community-based crisis response. Activities to be performed by the Contractor at the direction of EOHHS may include, but not be limited to:

   a. Stakeholder engagement activities;

   b. Request for information from providers;

   c. Revision of provider performance specifications; and

   d. Provider contracting, oversight and/or procurement related activities.

Section 2.8 BH Provider Network and Network Management

A. Establishment of BH Provider Network

As of the Operational Start Date, the Contractor shall have in effect and maintain a Network of Providers for the delivery of BH Covered Services set forth in **Appendix A-1**, in accordance with the terms of this Contract.

The Contractor shall:

1. Make best efforts to ensure that all network providers in good standing from the previous BH contract continue to participate in the Contractor's Provider Network and, accordingly, renew or execute, prior to the Operational Start Date, Provider Agreements with all such network providers.

2. Ensure that all Provider Agreements the Contractor initially executes with network providers from the previous BH contract are for a term of at least one year unless the Contractor obtains approval from EOHHS for a shorter time period.

3. Enter into Provider Agreements effective no later than January 3, 2023, with each CBHC identified in **Appendix A-3** to provide all CBHC component services (including Behavioral Health Urgent Care, AMCI, YMCI, Adult CCS and YCCS) and each Community Service Agency (CSA) identified in **Appendix A-2** to provide Intensive Care Coordination and Family Support and Training Services.

4. Maintain the ESP provider network for all ESP providers under contract with the Contractor prior to December 31, 2022, and ensure the delivery of ESP services on January 1 and January 2, 2023, and until notified by EOHHS in accordance with the provisions of **Appendix A-4**.

5. No later than three months prior to the Operational Start Date, or as otherwise agreed to by EOHHS, submit to EOHHS for its review and approval the Contractor's initial Provider Network. The Contractor shall submit to EOHHS for review and approval the new BH Provider Network following any reprocurement of the Contractor's providers.

6. Ensure that there are sufficient Network Providers to deliver all BH Covered Services in accordance with the terms of this Contract.

7. Develop a BH Provider Network Plan that:

    a. Ensures that the Provider Network is established in a fair and equitable manner, and in accordance with the requirements of this Contract and represents the full continuum of Behavioral Health Covered Services.

    b. Allows all interested providers who are in good standing, including independently practicing licensed social workers, licensed mental health counselors Licensed Alcohol and Drug Counselors 1 (LADC1), and licensed marriage and family therapists, to apply to become Network Providers.

8. Develop and maintain an up-to-date database that contains, at a minimum, the following information on Network Providers:

    a. Network Provider name and unique National Provider Identifiers (NPIs) for each such Network Provider;

b. contracted services;

c. site address(es) (street address, town, ZIP code, region of the state);

d. site telephone numbers;

e. site hours of operation;

f. emergency/after-hours provisions;

g. professional qualifications and licensing;

h. areas of specialty relating to Behavioral Health conditions and MassHealth populations;

i. cultural and linguistic capabilities;

j. malpractice insurance coverage and malpractice history;

k. credentialing status;

l. status as Supplier Diversity Office (SDO) certified business; and

m. Provider e-mail address.

9. Develop and maintain a list of BH Network Providers, sorted by type of service and by Network Providers' capability to communicate with Covered Individuals in their primary languages. This list shall be available to the Contractor's clinical staff at all times, and available to Network Providers, Covered Individuals, EOHHS, DMH and other interested parties upon their request and at no charge.

10. On a monthly basis and as requested by EOHHS, submit a complete database of all Network Providers via a system interface as directed by EOHHS in a form and format and according to data standards specified by EOHHS.

11. As further specified by EOHHS, contract with state agency providers as follows:

a. Include in its Provider Network state agency providers of inpatient mental health services, outpatient Behavioral Health, diversionary Behavioral Health services, Acute Treatment Services and Clinical Support Services as set forth in **Appendix A-1**.

b. Not require these state agency providers to indemnify the Contractor, to hold a license, or to maintain liability insurance; and

c. If required by EOHHS, include in its Provider Network or pay as out-of-network providers, other state agency providers as set forth in **Appendix A-1**.

B. BH Provider Network Requirements

1. The Contractor shall maintain and monitor a BH Provider Network sufficient to provide all BH Covered Individuals, including those with limited English proficiency or physical or mental disabilities, with adequate access to BH Covered Services across all regions of the state. As further directed by EOHHS, the Contractor shall maintain information about its BH Provider Network with respect to the above requirement and provide EOHHS with such information upon request.

2. The BH Provider Network shall be composed of a sufficient number of appropriately credentialed, licensed, or otherwise qualified BH Network Providers to meet the requirements of this Contract. As directed by EOHHS:

    a. Such Providers must be enrolled with EOHHS as specified by EOHHS.

    b. The Contractor may execute Provider Contracts for up to 120 days pending the outcome of EOHHS' enrollment process but must terminate a Provider Network immediately upon notification from EOHHS that the Network Provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider. The Contractor shall notify affected Covered Individuals of the termination.

3. The Contractor shall make best efforts to ensure that SDO certified businesses and organizations are represented in the Provider Network. The Contractor will submit annually the appropriate certification checklist on its efforts to contract with SDO-certified entities.

4. As requested by EOHHS, the Contractor shall, in a form and format specified by EOHHS, report to EOHHS data specifications related to its BH Network Providers including but not limited to whether each BH Network Provider is enrolled as a MassHealth provider, and any other information requested by EOHHS about its BH Network Providers including but not limited to each Provider's MassHealth billing ID, provider ID/service location (PID/SL), NPI, tax ID (or TIN), and known affiliations to other providers.

5. The BH Provider Network shall include a sufficient number of Providers with appropriate expertise in treating Covered Individuals with BH needs to address their care needs, including an adequate number of Providers with experience and expertise in various specialty populations.

6. In addition to ensuring its Network includes BH Providers who can address all Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM 5)(or current version as applicable) as diagnostic needs as described in the most recent publication, the Contractor shall ensure that its BH Provider Network must have the capacity to provide integrated care to individuals with complex needs across multiple specialty populations and co-occurring disorders, including:

    a. Serious and persistent mental illness;

b. Post-traumatic stress disorder, especially among children and adolescents;

c. Children and adolescents, including children and adolescents with Serious Emotional Disturbance and Autism Spectrum Disorder;

d. Physical disabilities and chronic illness;

e. Deaf and hard of hearing and blind or visually impaired;

f. HIV/AIDS;

g. Homelessness;

h. Child Welfare and juvenile justice;

i. Fire-setting behaviors;

j. Sex-offending behaviors;

k. Post-adoption issues;

l. Eating disorders; and

m. Substance use disorders

7. The Contractor shall ensure its Provider Network includes sufficient numbers of BH Network Providers with experience and expertise with the following populations of Covered Individuals:

a. Persons with physical disabilities;

b. Persons with chronic illness(es);

c. Children, adolescents and their families;

d. Persons who are homeless, including children and families;

e. Children in the Care and/or Custody of the Commonwealth;

f. Persons with criminal justice involvement;

g. Young adults who are transitioning out of state-sponsored programs as they turn 22;

h. Persons with intellectual and developmental disabilities;

i. Persons with brain injuries;

j. Persons with HIV/AIDS;

k. Pregnant women with substance use conditions;

l. Young children;

m. Older adults;

n. Persons from diverse cultural backgrounds, including persons whose primary language is not English;

o. Persons who are deaf or hard of hearing; and

p. Persons who are blind or visually impaired.

8. The Contractor shall provide coverage across all regions of the state.

9. The Contractor shall ensure the availability of the full range of BH Covered Services.

10. The Contractor shall provide access to BH Covered Services according to the standards set forth in **Section 2.9**.

11. The Contractor shall allow independently practicing clinicians with the following licenses to apply to become Network Providers: Licensed Independent Clinical Social Worker (LICSW), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC) and Licensed Psychologist.

12. In establishing and maintaining the Provider Network, the Contractor must consider the following:

    a. The anticipated enrollment in the PCC Plan and the PCACOs and estimated numbers of other MassHealth Covered Individuals who will receive BH Covered Services through the Contractor;

    b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific MassHealth populations enrolled with the Contractor;

    c. The numbers and types (in terms of training, experience, and specialization) of Providers required to timely furnish the BH Covered Services;

    d. The number of Network Providers who are not accepting new patients; and

    e. The geographic location of Providers and Covered Individuals, considering distance, travel time, the means of transportation ordinarily used by Covered Individuals, and whether the location provides physical access for Covered Individuals with disabilities.

13. The Contractor shall implement written policies and procedures for the selection and retention of Providers in accordance with 42 CFR 438.214, including but not limited to ensuring such policies and procedures for Providers do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

14. Share with MassHealth-contracted managed care entities and PCC Plan Providers any changes and/or updates to the CBHC provider network prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with the MassHealth-contracted MCOs, ACOs or PCC Plan Providers any information that pertains solely to individuals who are Covered Individuals or Uninsured Individuals or persons with Medicare only.

15. Share with MassHealth-contracted MCOs, ACOs, and PCC Plan Providers, any changes and/or updates to the list of CSAs prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with the MassHealth-contracted MCOs, ACOs or PCC Plan Providers any information that pertains solely to individuals who are Covered Individuals.

16. At the Covered Individual's request, the Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Covered Individual to obtain one outside the Provider Network, at no cost to the Covered Individual.

17. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, Covered Individuals with special health care needs, including individuals with disabilities, or other special populations served by the Contractor, by, at a minimum, having the capacity to, when necessary, communicate with Covered Individuals in languages other than English, communicate with individuals who are deaf, hard-of-hearing, or deaf blind, and making materials and information available in Alternative Formats as specified in this Contract.

18. The Contractor shall ensure that its Network Providers and Material Subcontractors meet all current and future state and federal eligibility criteria, standard and ad hoc reporting requirements, and any other applicable rules and/or regulations related to this Contract;

19. Out-of-Network Access

    The Contractor shall develop, maintain and utilize EOHHS-approved protocols to address situations when the Provider Network is unable to provide Covered Individual with adequate and timely access to necessary BH Covered Services as defined in **Section 2.9.C** and **42 CFR 438.206** Availability of services**.** The Contractor's protocols must ensure, at a minimum, the following:

    a. If the Contractor is unable to provide a Covered Individual with a particular BH Covered Service through its Provider Network, it will be adequately covered in a timely way out-of-network for as long as the Provider Network is not able to provide such BH Covered Services;

b. When accessing an out-of-network provider, the Covered Individual is able to obtain the same service or to access a provider with the same type of training, experience, and specialization as within the Provider Network;

c. That out-of-network providers must coordinate with the Contractor with respect to payment, ensuring that the cost to the Covered Individual is no greater than it would be if the services were furnished through the Provider Network;

d. That the particular service will be provided by the most qualified and clinically appropriate provider available taking into account the geographic location of the provider and the Covered Individual, considering distance, travel time, the means of transportation ordinarily used by Covered Individuals, and whether the location provides physical access for Covered Individuals with disabilities if applicable to the Covered Individual;

e. That the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification;

f. That the provider will be informed of his or her obligations under state or federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Covered Individual in his or her primary language;

g. That the only Provider available to the Covered Individual in the Provider Network does not, because of moral or religious objections, decline to provide the service the Covered Individual seeks;

h. That consideration is given for an out-of-network option in instances in which the Covered Individual's Provider(s) determines that the Covered Individual needs a service and that the Covered Individual would be subjected to unnecessary risk if the Covered Individual received those services separately and not all of the related services are available within the Provider Network; and

i. That the Contractor cover certain BH Covered Services furnished to a Covered Individual in another state in accordance with 42 CFR 431.52(b) and 130 CMR 450.109.

C. BH Provider Network Management

The Contractor shall:

1. Beginning on the Operational Start Date, develop and implement a strategy to manage the Provider Network with an emphasis on the following:

    a. Timely access to treatment for Covered Individuals;

    b. Quality of care;

    c. Application of principles of rehabilitation and recovery to service planning and service delivery;

    d. Reduction of health disparities;

    e. Measurement of outcomes for Covered Individuals over the course of receiving Behavioral Health Covered Services. The Contractor shall develop systems to measure outcomes based on goals set for a course of treatment;

    f. Full Integration of Behavioral Health Covered Service delivery across Mental Health and SUD providers, and with medical services provided by the Enrollee's PCC, Covered Individual's PCP, or other key health care Providers, including state agency providers;

    g. Cost-effectiveness of the delivery of BH Covered Services, and

    h. Effective care transitions and care continuity for Covered Individuals.

2. Ensure that its Provider Network management strategy includes at least the following:

    a. Actively monitoring the quality of care including effective use of evidence based practices and timely access to treatment provided to Covered Individuals under any Provider Contracts and any other subcontracts, including but not limited to the use of secret shoppers to confirm access;

    b. A systematic plan for utilizing Network Provider profiling and benchmarking data to identify and manage Network Providers who fall below established benchmarks and performance standards, and to replicate practices of Network Providers who consistently exceed benchmarks and performance standards;

    c. A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward improvement goals;

    d. Utilization of on-site visits to Network Providers at all Levels of Care, to support quality improvement efforts and benchmarking data; and

    e. Steps to ensure Network Provider compliance with the Contractor's performance specifications for each BH Covered Service.

3. Take appropriate management action, including the development and monitoring of corrective action plans for Network Providers whose performance is determined by the Contractor to be in need of improvement.

    a. The Contractor shall notify EOHHS of any Network Providers who are placed on a corrective action plan.

4. Take appropriate action related to Network Providers, as follows:

    a. Upon the Contractor's awareness of any disciplinary action or sanction taken against a Network Provider, either internally by the Contractor or by any oversight agency or any source outside of the Contractor's organization, such as the Board of Registration in Medicine, the Division of Registration, and the federal Centers for Medicare and Medicaid Services (CMS), immediately inform EOHHS's Business Support Services vendor of such action taken and work collaboratively with the vendor to maintain a process to share such information.

    b. If notified that MassHealth or another state Medicaid agency has taken an action or imposed a sanction against a Medicaid provider, including disenrollment of any such provider from the Medicaid program, review the Provider's performance related to this Contract and take any action or impose any sanction that the Contractor determines is appropriate, including disenrollment from the Contractor's Provider Network.

5. In collaboration with and as further directed by EOHHS, develop and implement BH Network Provider quality improvement activities directed at ensuring that Network Providers:

    a. use the CANS Tool in their Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services for Covered Individuals under the age of 21; and

    b. access and utilize the CANS IT System to input information gathered using the CANS Tool to identify whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

6. 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 the prior review and approval of EOHHS;

7. Establish and implement policies and procedures to increase the Contractor's capabilities to share information among providers involved in Covered

Individuals' care, including increasing connection rates of Network Providers to the Mass HIway, adopting and integrating interoperable certified Electronic Health Records (EHR) technologies (such as those certified by the Office of the National Coordinator (ONC)), enhancing interoperability, and increasing the use of real time notification of events involving BH treatment and access (such as but not limited to admission of a Covered Individual to an emergency room or other BH treatment setting).

8. Propose by the Operational Start Date, and implement subject to EOHHS approval, a Network management strategy to engage with PCCs, specialty Providers, high-volume prescribers, and hospital ED to improve access for Covered Individuals who may be under- or over-utilizing Behavioral Health services. The proposal shall include but is not limited to methods for the Contractor's staff and its Behavioral Health Network Providers to use to identify Enrollees who may benefit from participation in the Care Management Program described in **Section 2.5**;

9. Propose methods the Contractor will use to engage foster parents and other individuals with physical custody of Children in the Care and/or Custody of the Commonwealth in such children's health care needs to ensure that they obtain Early and Periodic Screening, Diagnosis and Treatment (EPSDT), periodic and inter-periodic screens and Medically Necessary follow-up medical dental and Behavioral Health services; and

10. Propose methods the Contractor will use to establish and maintain specific supports for Providers of Behavioral Health, Primary Care, and specialty health care who provide MassHealth Covered Services to Children in the Care and/or Custody of the Commonwealth to ensure continuity of care for Children in the Care and/or Custody of the Commonwealth who change Providers due to changes in their foster care arrangements or for other reasons.

11. Modify, in whole or in part, any proposal submitted pursuant to this Section, as required by EOHHS to obtain EOHHS' approval.

D. Network Provider Policy and Procedure Manual

The Contractor shall:

1. At least three months prior to the Operational Start Date, develop and submit to EOHHS for approval a Provider policy and procedure manual, and, following EOHHS approval, publish the manual on Contractor's website and electronically distribute a hyperlink to the manual to all Network Providers. At a Network Provider's request, also electronically distribute the manual to the Providers. The manual shall include, at a minimum, information on:

    a. The Contract, the Contractor, and program priorities;

b. How to verify a Covered Individual's eligibility for MassHealth Behavioral Health Covered Services;

c. Network Provider Credentialing Criteria;

d. Provider Network management;

e. Procedures for service authorization, concurrent review, extensions of lengths of stay, and retrospective reviews for all BH Covered Services;

f. Clinical Criteria for admission, continued stay, and discharge for each BH Covered Service;

g. Administrative and billing instructions, including a list of procedure codes, units and payment rates;

h. How to appeal payment and service denial decisions;

i. Reporting requirements for Serious Reportable Events and Reportable Adverse Incidents; and

j. Performance specifications for each Behavioral Health Covered Service.

2. As necessary, modify or supplement the policy and procedure manual by distributing periodic notices to Network Providers;

3. Review the manual at least biannually and amend it, if necessary, in consultation with EOHHS; and

4. Redistribute the amended portions of the manual to Network Providers.

E. Performance Specifications

The Contractor shall:

1. Require all Network Providers to accept the Contractor's performance specifications that have been approved by EOHHS;

2. Develop and maintain performance specifications for Network Providers and develop performance specifications for new BH Covered Services; and

3. At least annually, review and update as necessary the performance specifications including any new performance specifications that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

F. BH Network Provider Protocols

1. The Contractor shall develop, maintain and utilize EOHHS-approved Network Provider protocols. The protocols must address the following:

a. How the Contractor intends to ensure, for a particular Covered Individual's needs, that a qualified and clinically appropriate Network or non-Network Provider:

1) is available to provide the particular BH Covered Service in a timely manner;

2) is accessible within the access standards required by the Contract, taking into account the availability of public transportation;

3) is accessible to individuals with physical disabilities, if appropriate; and

4) has the ability, either directly or through a skilled medical interpreter, to communicate with the Covered Individual in his/her primary language.

b. How the Contractor intends to facilitate communication between Network Providers and the Contractor, and between Network Providers and PCCs, in a manner that engages the Providers and overcomes Barriers to communication.

2. The Contractor shall require Network Providers to submit to the Contractor a written report of all Reportable Adverse Incidents, using the form found in **Appendix F** or other similar form acceptable to EOHHS, according to the following guidelines:

a. Network Providers of 24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents involving a Covered Individual.

b. Network Providers of non-24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents involving a Covered Individual.

c. The Contractor shall require Network Providers to coordinate MassHealth Covered Services with the Covered Individual's care manager or BH CP where the Covered Individuals are receiving Care Management services through the Contractor or CP services through their PCACO and/or the case manager when the Covered Individual is receiving case management through a state agency (e.g., DMH, DCF, DDS, and DYS).

3. The Contractor shall require Network Providers to comply with DPH's regulations barring payment for services related to a Serious Reportable Event.

4. The Contractor shall require Network Providers to comply with all of the following Massachusetts regulations and DMH policy memorandums:

a. DMH Policy 14-01 of September 29, 2014, on informed consent, found at https://www.mass.gov/doc/14-01-informed-consent-policy-effective-september-29-2014/download , or any successive policy or regulation;

b. DMH regulations on human rights and restraint & seclusion at 104 CMR 27 and 104 CMR 28, or any successive regulation, and any other applicable DMH regulations; and

c. M.G.L. c. 123, § 23.

5. The Contractor shall require its Network Providers of Community-Based Acute Treatment Services, and Transitional Care Units to comply with Department of Early Education and Care (DEEC) standards for the licensure or approval of residential programs serving Members under 18, as set forth in 606 CMR 3.00, et seq. For those CBAT, ACBAT, and TCU Providers that are not located in a site licensed by DEEC, the Contractor shall ensure that these programs are located in a facility that is licensed by DMH and/or DPH. The Contractor shall reasonably assist its Network Providers of Community-Based Acute Treatment Services in obtaining accreditation, as further specified by EOHHS.

6. The Contractor shall require its Network Providers to inform Covered Individuals of their rights under DMH regulations concerning human rights.

7. The Contractor shall comply with EOHHS protocols to ensure access to Behavioral Health Covered Services and tracking in the EOHHS Data Warehouse and MMIS systems by adhering to the following requirements:

a. Maintain a unique Network Provider identification number for each Network Provider, as described in **Section 2.8.A**.

b. Submit to EOHHS's Business Support Services vendor by the Operational Start Date a list of all Network Providers who are both MassHealth Providers and Network Providers (dual Providers). The Contractor shall inform EOHHS's Business Support Services vendor upon enrolling or disenrolling any dual Provider from its Provider Network.

c. Inform EOHHS's Business Support Services vendor immediately upon enrolling any Provider who is not also a MassHealth Provider in its Provider Network. Such notification shall include the following data elements:

1) Network Provider name, address and telephone number;

2) Legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a, name), if different from the above;

3) Network Provider or legal entity's tax identification number; and

4) Effective date of the Network Provider's enrollment in the Provider Network.

5) The Contractor shall submit to the Business Support Services vendor all updates to the list or its data elements whenever they occur.

8. The Contractor shall require, and develop a mechanism to enable, its Network Providers to:

a. Report to the Contractor when it has received an overpayment;

b. Return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified; and

c. Notify the Contractor in writing of the reason for the overpayment;

G. Provider Credentialing, Recredentialing, and Board Certification

1. General Provider Credentialing

The Contractor shall implement written policies and procedures that comply with the requirements of 42 CFR 438.214 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 in accordance with **Appendix E-1** that all Providers within the Contractor's Provider Network are credentialed according to such policies and procedures. The Contractor shall at a minimum:

a. Participate in any effort by EOHHS to standardize credentialing processes across EOHHS and its MassHealth managed care entities and fee-for-service programs.

b. Require Network Providers to meet the Credentialing Criteria approved by EOHHS.

c. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Network Providers and all other licensed or certified Network 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 NCQA and relevant state regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13. The basic components of these processes shall include a review of the following:

1) licensing, accreditation, certification, training, specialty board eligibility or certification;

2) current status of professional license, restrictions, and history of any loss of licensure in any state;

3) DEA number and copy of certification, where applicable;

4) hospital privileges, name of hospitals, and scope of privileges, where applicable;

5) record of continuing professional education;

6) location, service area and telephone numbers of all offices, hours of operation, and provisions for Emergency care and backup;

7) areas of special experience, skills and training;

8) cultural and linguistic capabilities;

9) review of Covered Individual satisfaction and any complaints made or Grievances filed against the Network Provider within the past two years;

10) physical accessibility for persons with disabilities;

11) malpractice insurance, carrier name, amount of coverage, copy of the face sheet, and scope of coverage;

12) malpractice history, pending claims, and successful claims against the Provider;

13) Medicare, Medicaid, federal tax identification number, and Social Security numbers;

14) reference check;

15) for facility-based Network Providers, a site visit and evidence of a training program for staff on the appropriate and safe use of restraint and seclusion to the extent that the facility's license permits the use of seclusion, and

16) for Network Providers of 24-hour services, evidence of a training program for staff on the appropriate and safe use of restraint and seclusion.

d. Ensure that all Network 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 NCQA and relevant state regulations;

e. Maintain a documented re-credentialing process that requires that physician Providers and other licensed and certified 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. Such processes shall also be consistent with any uniform re-credentialing policies specified by EOHHS addressing Behavioral Health Providers, and any other EOHHS-specified Providers;

f. Ensure that Network Providers are recredentialed every three years, at a minimum, and take into consideration various forms of data, including but not limited to, Grievances, results of quality reviews, Covered Individual satisfaction surveys, and Utilization Management information;

g. Designate the Contractor's department(s) and staff who will be directly responsible for credentialing and recredentialing Network Providers;

h. To the extent permitted by law and upon request, provide Covered Individuals or their legal guardians with information in the Network Provider database, with the exception of the information described in **Section 2.8.G.1.c.11-16** above;

i. Ensure that that the credentialing process does not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;

j. Not authorize any Network Providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Covered Individuals, and deny payment to such Network Providers for any service provided.

1) The Contractor shall, at a minimum, check the Board of Registration in Medicine (BORIM) website at least once per month and the U.S. Department of Health and Human Services Office of the Inspector General's (OIG) List of Excluded Individuals Entities (LEIE) or Medicare Exclusion Database (MED) websites before the Contractor contracts with a Provider to become part of its Provider Network, at the time of a Provider's credentialing and recredentialing, and at least monthly thereafter.

2) The Contractor shall notify a Network Provider within three business days that, due to its MassHealth, Medicare, or another state's Medicaid program termination or suspension or a state or federal licensing action, such Network Provider is terminated or suspended, as appropriate, from the Contractor's Provider

Network, and is no longer eligible to treat Covered Individuals. The Contractor shall have a process in place to immediately effectuate such termination or suspension.

3) When the Contractor terminates or suspends a Network Provider from its Network, or rejects a potential provider's application to join the Network, based on such Provider's termination or suspension with MassHealth, Medicare, or another state's Medicaid program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify EOHHS of the Network Provider termination, suspension or rejection, and the reason thereof, within three business days.

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

5) This Section does not preclude the Contractor from suspending or terminating Network Providers for cause prior to such Network Provider's ultimate suspension and/or termination by EOHHS from participation in MassHealth.

k. Not employ or contract with a Provider, or otherwise pay for any items or services furnished, directed or prescribed by a Provider that has been excluded from participation in federal health care programs by the OIG 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 CFR 1001.1801 and 1001.1901.

l. Ensure that no Network Provider engages in any practice with respect to any Covered Individual 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 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

m. Search for the names of parties disclosed during the credentialing process in the BORIM, OIG LEIE, and Medicare MED exclusion or debarment databases and the MassHealth exclusion list, and do not contract with parties that have been terminated from participation under Medicare or another state's Medicaid program.

n. Notify EOHHS when a Network Provider fails credentialing or re-credentialing because of a program-integrity reason, including those reasons described in this Section, and provide information required by EOHHS or state or federal laws, rules, or regulations.

o. Demonstrate to EOHHS, by reporting annually in accordance with **Appendix E-1**, that all Network Providers within the Contractor's Provider Network are credentialed according to this Section.

2. Network Provider Qualifications

The Contractor shall:

a. Execute Provider Agreements or enter into other arrangements for BH Covered Services only with facility-based Providers that satisfy the following criteria:

1) They are financially stable, as determined by the Contractor;

2) They have established and maintain a Quality Management program, as described in **Section 2.13**;

3) They comply with policies and regulations with respect to patient rights and privileges, as applicable;

4) They maintain records consistent with current professional standards and EOHHS regulations, as well as systems for accurately documenting the following information for each Covered Individual receiving BH Covered Services:

a) demographic information, including race, ethnicity, preferred language, disability status, sexual orientation, and gender identity;

b) clinical history;

c) Behavioral Health Clinical Assessments;

d) treatment plans;

e) services provided in sufficient detail to justify payment;

f) contacts with Covered Individuals' family, guardians, or significant others; and

g) treatment outcomes;

5) Are responsive to linguistic, cultural and other unique needs of any member of a cultural, racial or linguistic minority, or other special population in the region in which they provide services;

6) Have the capacity to communicate with Covered Individuals in languages other than English, when necessary, as well as with those who are deaf or hearing-impaired;

7) Satisfy all federal and state requirements for affirmative action;

8) Satisfy all federal and state legal requirements regarding the Provider's physical plant and premises;

9) Comply with all applicable anti-discrimination requirements described in 42 CFR 438.3(d)(3) and (4);

10) Comply with all other applicable state and federal laws;

11) Meet the Credentialing Criteria; and

12) Have been credentialed pursuant to the policies and procedures specified in **Section 2.8.G**.

b. Ensure that, in addition to the criteria set forth in **Section 2.8.G.2.a**, above, those facility-based Network Providers that are Network Providers of Inpatient Services are fully licensed by DMH and by DPH as applicable. In addition, ensure that such Providers:

1) Comply with DMH regulations concerning human rights set forth in 104 CMR 27.13 and 14 and 104 CMR 28.11, including ensuring that human rights activities are overseen by a human rights committee and officer, and provide training for staff and education for Covered Individuals regarding human rights. To the extent permissible under **Section 5.2**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

2) Comply with DMH's regulations concerning restraint and seclusion. To the extent permissible under **Section 5.2**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

3) Submit to the Contractor evidence of implementation of the training programs described in **Section 2.8.G.2.b.1-2** as part of investigations of Serious Reportable Events, implementation of corrective action plans that involve human rights, and the use of restraint and seclusion;

4) Notify the DMH Licensing Unit of an inpatient Provider's non-compliance with these requirements and collaboratively determine whether additional Contractor action is appropriate;

5) Develop organizational and clinical linkages with each of the high-volume referral source CBHCs, as identified by EOHHS, hold regular meetings, and communicate with the CBHCs on clinical and administrative issues, as needed, to enhance continuity of care for Covered Individuals; and

c. Preferentially execute Provider Agreements or enter into other arrangements for the provision of BH Covered Services with Providers that demonstrate a commitment to the principles of rehabilitation and recovery from mental illness and addiction, including a focus on recovery-oriented services, consumer and family involvement in program management, a strength-based approach to working with children and their families, and training for staff on such principles.

d. 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 Covered Individuals and shall deny payment to such providers for services provided. In addition:

1) The Contractor shall monitor Providers and prospective Providers by monitoring all of the databases described in **Appendix J**, at the frequency described in **Appendix J**.

2) The Contractor shall submit a monthly Excluded Provider Monitoring Report to EOHHS, as described in **Appendix E-1**, which demonstrates the Contractor's compliance with this **Section 2.8**. At the request of EOHHS, the Contractor shall provide additional information demonstrating to EOHHS' satisfaction that the Contractor complied with the requirements of this Section;

3) 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. In the event EOHHS suspends payment to a provider, including but not limited to when there is an investigation of a credible allegation of fraud, the Contractor shall also suspend such payment, if directed to do so by EOHHS; provided, however, that the Contractor may propose to EOHHS that there is good cause for the Contractor not to suspend, or to suspend in part, such payments. EOHHS shall approve or deny the Contractor's proposal.

4) The Contractor shall notify EOHHS when it terminates, suspends, or declines a Provider from its Network or for any other independent action including;

5) This Section does not preclude the Contractor from suspending or terminating Providers for reasons unrelated to the possible suspension and/or termination from participation in MassHealth, Medicare or another state's Medicaid program;

e. Not employ or contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a Provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901. In addition, pursuant to Sections 1903(i), including 1903(i)(2)(B), of the Social Security Act, the Contractor shall 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) 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, title VXIII, or XX or under title XIX pursuant to Sections 1128, 1128A, 1156 or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after reasonable time period after reasonable notice has been furnished to the person);

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

g. Ensure that no credentialed Provider engages in any practice with respect to any Covered Individual 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 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

H. Provider Profiling

1. The Contractor must conduct profiling activities for Behavioral Health Network Providers, PCC Plan Providers, as directed by EOHHS including in accordance with **Section 2.19.D** for PCC Plan Providers, and other Provider types, at least annually. As part of its quality activities, the Contractor must document the methodology it uses to identify which and how many non-PCC Plan Providers to profile, and to identify measures to use for profiling such Providers.

2. Provider profiling activities for Network Providers 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 Covered Individuals 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 MassHealth-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.

3. The Contractor shall use the results of its BH 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 nonfinancial 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.

4. 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.

I. Provider Education

The Contractor shall develop an education and training plan that provides appropriate information and learning sessions for Network Providers and their staff, and that aligns

with the Roadmap for Behavioral Health Reform's workforce retention goals to increase provider participation in insurance (including MassHealth) and strengthen workforce diversity and competency. Such education and training plan shall be submitted to EOHHS for approval and shall include, at a minimum:

1. A schedule for the development and release of educational materials;
2. A schedule for the development and timing of training sessions;
3. Regional training opportunities for Network Providers' clinical and administrative staff; and
4. Proposed education and training topics, including but not limited to:
    a. evidence-based practices for Behavioral Health clinicians;
    b. new changes to policies and procedures prior to their implementation;
    c. basics of MassHealth coverage and payment requirements;
    d. cultural and linguistic competency;
    e. Health Equity; and
    f. quality improvement efforts and the Network Provider's role, including linkages across Behavioral Health and physical health services.

J. Collaboration in Policy Development

The Contractor shall participate in any EOHHS efforts related to the development of policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, that support access, coordination, and continuity of Behavioral Health care, reduce emergency department utilization and lengths of time awaiting placement in inpatient and 24-hour levels of care, and address the opioid epidemic. Such policies or programs may include, but are not limited to, the development of:

1. Specialized inpatient services;
2. New diversionary and urgent levels of care;
3. Expanded substance use disorder treatment services; and
4. Services and supports tailored to populations with significant Behavioral Health needs, including justice involved and homeless populations.

Section 2.9 Accessibility and Availability of BH Covered Services

A. General

The Contractor shall ensure adequate access to BH Covered Services for all Covered Individuals and shall further facilitate access to non-BH Covered Services. All such

services shall be accessible and available to Covered Individuals in a timely manner. Accessibility shall be defined as the extent to which the Covered Individual can obtain services at the time they are needed and refers to both telephone access and ease of scheduling an appointment. Availability shall be defined as the extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of Covered Individuals.

The Contractor shall:

1. Ensure access to BH Covered Services in accordance with state and federal laws for persons with disabilities by ensuring that BH Network Providers are aware of and comply with such laws so that physical and communication Barriers do not inhibit Covered Individuals from obtaining services under the Contract; and

2. Assure EOHHS that it has the capacity to serve Covered Individuals in accordance with the access and availability standards specified in **Sections 2.9.B and C**. by submitting reports specified in **Appendix E-1**, on an annual and ad-hoc basis, and whenever there is a significant change in operations of the BH Provider Network and significant changes to the BH Provider Network itself, that would affect the adequacy and capacity of services. Significant changes shall include, but are not limited to:

    a. Changes in BH Covered Services;

    b. Enrollment of a new population in the Contractor's Plan;

    c. Changes in MassHealth benefits, and

    d. Changes in Provider payment methodology.

    If the Contractor is not in compliance with the access and availability standards specified in **Sections 2.9.B and C**, the Contractor shall take corrective action necessary to come into compliance with such standards.

B. Accessibility

The Contractor shall ensure that Covered Individuals have access to BH Covered Services as provided below.

1. Emergency Services: Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Covered Individuals who present at any qualified Provider, whether a Network Provider or a non-Network provider.

2. Adult Mobile Crisis Intervention (AMCI) and Youth Mobile Crisis Intervention (YMCI) Services: Within 60 minutes of time of the Covered Individual's readiness to receive such services.

3. For Emergency Department-based Crisis Intervention Mental Health Services: Crisis Evaluation- within 60 minutes of time of the Covered Individual's readiness to receive such an assessment.

4. Behavioral Health Urgent Care: Within 48 hours for services that are not Emergency Services, Mobile Crisis Intervention, or routine services.

5. All Other Behavioral Health Services: Within 14 calendar days.

6. 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. Medication Management – within 14 calendar days of discharge;

    c. Other Outpatient Services – within seven calendar days of discharge; and

    d. Intensive Care Coordination Services – within the time frame directed by EOHHS.

7. The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercially-insured individuals or MassHealth Fee- For-Service if the Provider serves only Covered Individuals or other Members.

8. 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.B** and shall promptly address any access deficiencies, including but not limited to taking corrective action if there is a failure to comply by a Provider. Annually, in accordance with **Appendix E-1**, the Contractor shall evaluate and report to EOHHS Network-wide compliance with the access standards specified in **Section 2.9.B**.

C. Availability

The Contractor shall:

1. Execute and maintain written contracts with Providers to ensure that Covered Individuals have access to BH Covered Services within a reasonable distance and travel time from the Covered Individual's residence, as provided below. The Contractor shall take into account both walking and public transportation.

2. Ensure that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Covered Individuals with physical or mental disabilities.

3. Monitor the practice of creating waiting lists for Covered Individuals who seek outpatient BH Covered Services. If the Contractor determines that a Network Provider has established a waiting list, the Contractor shall create a plan to identify such Network Providers and help them reduce such waiting lists, with the goal of eliminating them. Such activity shall include but not be limited to the Contractor directly assisting Covered Individuals to find an appropriate alternative Provider. The Contractor shall further ensure that:

    a. Waiting lists are established and maintained in such a way as to not violate the provisions of M.G.L. c. 151B, including waiting for appointments after the initial appointment; and

    b. Network Providers with waiting lists refer Covered Individuals to other qualified Network Providers who do not have waiting lists.

4. Maintain a sufficiently broad and robust Provider Network to ensure that, at a minimum, 90 percent of Covered Individuals have access to all Medically Necessary Behavioral Health Covered Services according to the following standards:

    a. Two of each of the following types of providers within 60 miles or 60 minutes travel time from Covered Individuals' residences, whichever requires less travel time:

        1) Inpatient mental health services (adults)

        2) Inpatient mental health services (adolescent)

        3) Inpatient mental health services (child)

        4) Inpatient SUD services (ASAM 4.0)

    b. Two of each of the following types of providers within 30 minutes or 30 miles:

        1) ATS

        2) CSS level 3.5

        3) CBAT-ACBAT-TCU

        4) PHP

        5) IOP

        6) RRS level 3.1

        7) ABA

        8) IHBS

9) IHT

10) TM

11) SOAP

12) BH outpatient (including psychiatry and psych APN)

13) CSP

14) Recovery Support Navigator

15) PDT

16) Recovery Coach

17) CPS

18) OTP

c. CBHCs in accordance with the geographic distribution set forth in **Appendix A- 3**;

d. Intensive Care Coordination and Family Support and Training Services provided by Community Service Agencies as available based on the CSA Provider list in **Appendix A-2**;

e. Other Intensive Home and Community-Based Services, which require Network Providers to travel to the Covered Individual's residence for services, must be available in all cities and towns in the Commonwealth; and

f. All other BH Covered Services within 30 miles or 30 minutes' travel time from the Covered Individual's residence, whichever requires less travel time.

5. Notwithstanding the generality of the foregoing, ensure access to at least one Network Provider, of each BH Covered Service in every geographic region of the state with more than 2.5 percent of Covered Individuals or, as determined by EOHHS, to the extent that qualified, interested Providers are available.

6. Ensure that access to BH Covered Services for Covered Individuals is consistent with the degree of urgency, as set forth in **Section 2.9B**.

7. Offer Covered Individuals who require readmission to Inpatient Mental Health Services readmission to the same Network Provider when there is a bed available in that facility.

8. Include, in its network of Community-Based Acute Treatment providers, providers with the clinical expertise to provide specialized CBAT services to

youth with ASD/IDD as directed by EOHHS. The Contractor shall pay such providers at the rate specified in **Appendix L**.

9. Permit Covered Individuals to self-refer to any BH Network Provider of their choice for Medically Necessary Behavioral Health Covered Services and to change BH Providers at any time;

10. Ensure that Covered Individuals have access to a choice of at least two Network Providers who provide Behavioral Health Services to the extent that qualified, willing Providers are available. The Contractor shall ensure that non-English speaking Covered Individuals have a choice of at least two BH Providers within each BH Covered Service as described in **Section 2.9.C.4** in identified Prevalent Languages, provided that such provider capacity exists within a service area.

11. Demonstrate access and availability of BH Covered services by complying with all applicable reporting requirements, including identifying, taking into consideration, and separately reporting on provider specialists with limited Network Provider Agreements, such as single case agreements.

12. At least quarterly, identify Network Providers included in the Contractor's Provider Directory who have not submitted at least two claims for BH Covered Services to Covered Individuals in the past 12 months. The Contractor shall report a list of such providers to EOHHS by BH Covered Service type and geographic location along with the Contractor's network adequacy reports. The Contractor shall examine and describe in its report to EOHHS the extent to which Covered Individuals have meaningful access to these BH Providers in the Network and whether these BH Providers should remain listed in the Provider Directory.

13. At least quarterly, conduct secret shopper and other activities to ensure that the Contract's access requirements are met, and report on findings to EOHHS within 30 days of the end of the quarter, including how the Contractor intends to address issues identified as part of these activities.

14. If the Contractor or EOHHS identifies or anticipates that the Provider Network will not be sufficient to meet the access standards of this Contract for a Covered Service in any location or for any population of Covered Individuals, the Contractor shall notify EOHHS of its strategy for enhancing its network and its contingency plan for connecting impacted Covered Individuals to care.

D. Other Accessibility and Availability Requirements

1. The Contractor may request an exception to the accessibility and availability standards set forth in this Section by submitting a written request to EOHHS. EOHHS will grant such a request only if:

   a. Such request includes alternative standards that are equal to or better than the usual and customary community standards for accessing care and the

standards specified in this Section. Such requests must include data on local providers available to the non-Medicaid population.

b. Upon approval by EOHHS, the Contractor shall notify Covered Individuals in writing of such alternative access standards.

c. If EOHHS grants the Contractor an exception to a specific accessibility or appointment availability standard, the exception is limited to the identified provider type and geographic region and is granted for a period of up to one (1) year, at which point the Contractor may submit a new request. The Contractor shall describe how it will reasonably deliver Covered Services to Enrollees who may be affected by the exception and how it will work to increase access to the provider type in the designated geographic region.

d. The Contractor shall monitor, track, and at least annually report to EOHHS on the delivery of such Covered Services to Covered Individuals potentially affected by the exception.

2. Direct Access to Specialists

For Covered Individuals including, but not limited to, Covered Individuals with special health care needs, determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow Covered Individuals direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the Covered Individual's condition and identified needs.

3. Through the execution of Provider Agreements, maintain and monitor a Network of appropriate providers that is sufficient to provide adequate access to all BH Covered Services for all Covered Individuals, including those with limited English proficiency or physical or mental disabilities. When directed by EOHHS, such Providers must be enrolled with the Contractor as specified by EOHHS. The Contractor may execute Network Provider agreements for up to 120 days pending the outcome of EOHHS's enrollment process, but must terminate a Network Provider immediately upon notification from EOHHS that the Network Provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider. The Contractor shall notify affected Covered Individuals of the termination.

4. Assure EOHHS that it has the capacity to service expected enrollment of Covered Individuals in accordance with the accessibility and availability standards specified in this Section by submitting the access and availability reports specified in **Appendix E-1**.

E. Certification to EOHHS

The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with 42 CFR 438.207(d). Such information shall include a certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding network adequacy, as well as any supporting documentation specified by EOHHS.

If the Contractor does not comply with the access standards specified in this Section, the Contractor shall take corrective action necessary to comply with such access standards and may be subject to financial penalties or other sanctions.

Section 2.10 Customer Services for Covered Individuals

A. Written Materials, Electronic Information and Handbooks

1. Written Materials

a. Unless otherwise provided in this Contract, the Contractor must ensure that all written materials provided by the Contractor to Covered Individuals:

1) Are Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor's membership;

2) Are produced in a manner, format, and language that may be easily understood by persons with limited English proficiency;

3) Are translated into Prevalent Languages of the Contractor's membership;

4) Are made available in Alternative Formats upon request free-of-charge, including video and audio; and information is provided about how to access written materials in those formats and about the availability of free auxiliary aids and services, including, at a minimum, services for Covered Individuals with disabilities;

5) Are mailed with a language card that indicates that the enclosed materials are important and should be translated immediately, and that provides information on how the Enrollee may obtain help with getting the materials translated;

6) Use a font size no smaller than 12 point; and,

7) Include a large print tagline (i.e., no smaller than 18 point font size).

b. The Contractor shall ensure all written materials intended for general distribution to Covered Individuals, Uninsured Individuals, Providers and

Primary Care Clinicians (PCCs) are up to professional business standards, and in compliance with 42 CFR 438.10, before submitting them to EOHHS for review and approval and prior to publication.

2. Electronic Information

The Contractor may only provide Covered Individuals information in electronic form if the following requirements are met:

a. The format is readily accessible;

b. The information is placed in a location on the Contractor's web site that is prominent and readily accessible;

c. The information is provided in an electronic form which can be electronically retained and printed;

d. The information is consistent with the content and language requirements of this Contract; and

e. The Enrollee is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days.

3. Handbook

a. The Contractor must develop, using a model to be provided by EOHHS to the Contractor, a Covered Individual handbook, which serves as a summary of benefits and coverage and will be included in the PCC Plan and PCACO, or utilized as a separate handbook for those Covered Individuals that are not enrolled in the PCC Plan or a PCACO.

b. At a minimum, this handbook shall contain all of the information required by 42 CFR 438.10(g), including:

1) The benefits provided by the Contractor;

2) How to access BH Covered Services, including the amount, duration and scope of BH Covered Services, in sufficient detail to ensure that Covered Individuals understand the benefits to which they are entitled and the procedures for obtaining such benefits, including the Contractor's toll-free telephone line(s), authorization requirements, information regarding applicable access and availability standards, any cost sharing, self-referral, and referral by family members or guardians, a Provider, PCP or community agency;

3) Inform Covered Individuals of the availability of assistance through the MassHealth Contact Center for help with determining

where and how to access non-BH Covered Services. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the handbook must inform Covered Individuals that the service is not covered by the Contractor;

4) The name and customer services telephone number for all Material Subcontractors that provide BH Covered Services to Covered Individuals unless the Contractor retains all customer service functions for such BH Covered Services;

5) The BH Covered Services that do not require authorization or a referral from the Covered Individual's PCP;

6) The extent to which, and how, Covered Individuals may obtain benefits, including Emergency Services, from out-of-network providers;

7) The role of the PCP, and the policies on referrals for specialty care and for other benefits not furnished by the Covered Individual's PCP;

8) How to obtain information about Network Providers;

9) The extent to which, and how, after-hours and Emergency Services and Poststabilization Care Services are covered, including:

    a) What constitutes an Emergency Medical Condition, Emergency Services, and Poststabilization Care Services;

    b) The fact that prior authorization is not required for Emergency Services;

    c) How to access the Contractor's toll-free 24-hour Clinical Advice and Support Line,

    d) The process and procedures for obtaining Emergency Services, including the use of the 911-telephone system;

    e) The services provided by CBHCs and how to access them;

    f) The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services; and

    g) The fact that the Covered Individual has a right to use any hospital or other setting for Emergency Services;

10) Covered Individual cost sharing;

11) Any restrictions on freedom of choice among Network Providers;

12) The availability of free oral interpretation services at the Plan in all non-English languages spoken by Covered Individuals and how to obtain such oral interpretation services;

13) The availability of all written materials that are produced by the Contractor for Covered Individuals in Prevalent Languages and how to obtain translated materials;

14) The availability of all written materials that are produced by the Contractor for Covered Individual in Alternative Formats and how to access written materials in those formats and the availability of auxiliary aids and services;

15) The toll-free Covered Individual services telephone number and hours of operation, and the telephone number for any other unit providing services directly to Covered Individuals;

16) The rights and responsibilities of Covered Individuals;

17) Information on Grievance, Internal Appeal, and Board of Hearing (BOH) procedures and timeframes, including:

    a) The right to file Grievances and Internal Appeals;

    b) The requirements and timeframes for filing a Grievance or Internal Appeal;

    c) The availability of assistance in the filing process;

    d) The toll-free numbers that the Covered Individual can use to file a Grievance or an Internal Appeal by phone;

    e) The fact that, when requested by the Covered Individual, BH Covered Services will continue to be provided if the Covered Individual files an Internal Appeal or a request for a BOH hearing within the timeframes specified for filing, and that the Covered Individual may be required by EOHHS to pay the cost of services furnished while a BOH Appeal is pending, if the final decision is adverse to the Covered Individual;

    f) The right to obtain a BOH hearing;

    g) The method for obtaining a BOH hearing;

    h) The rules that govern representation at the BOH hearing; and

i) The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information;

18) Information on advance directives in accordance with **Section 5.1.E**;

19) Information on the access standards specified in **Section 2.9.B**;

20) Information on how to report suspected fraud or abuse; and

21) Information about continuity and transition of care for new Covered Individuals.

c. The Contractor shall distribute this handbook to each Covered Individual as follows:

1) For each existing Covered Individual, the Contractor shall:

a) Mail a printed copy of the handbook to the Covered Individual at his or her mailing address;

b) Provide an electronic copy of the handbook by electronic mail after obtaining the Covered Individual's agreement to receive the information by electronic mail;

c) Post the handbook on its website and advise the Covered Individual, in both paper and electronic form, that the handbook is available on the internet, including the appropriate URL, provided that Covered Individuals with disabilities who cannot access the handbook online are provided auxiliary aids and services upon request at no cost; and

d) Provide the handbook by any other method that can reasonably be expected to result in the Covered Individual receiving the information contained in the handbook.

2) For new Covered Individuals, the Contractor shall, within a reasonable time after receiving notice of the Member's enrollment with the Contractor, distribute the handbook in accordance with **Section 2.10.A.3.c.1** above.

d. The Contractor shall give Covered Individuals notice of any significant change in the information set forth in **Section 2.10.A.3**, as determined by EOHHS, at least 30 days before the intended effective date of the change.

4. Notices

The Contractor shall develop Covered Individual notices using models to be provided by EOHHS to the Contractor.

B. Covered Individual Services Department, Standards, and Staff

1. The Contractor must maintain a Covered Individual services department to assist Covered Individuals and their family members or guardians, and other interested parties in learning about and obtaining services under this Contract.

2. The Contractor must maintain employment standards and requirements (e.g., education, training, and experience) for Covered Individual services department staff and provide a sufficient number of staff for the Covered Individual services department.

C. Customer Service Telephone Line, Training, and Requirements

1. The Contractor must operate a toll-free Covered Individual services telephone line a minimum of nine hours per day during normal business hours, Monday through Friday, which shall:

   a. Have at least 90% of calls answered by a trained customer service department representative (non-recorded voice), within 30 seconds or less as reported in accordance with **Appendix E-1**;

   b. Have less than a 5% abandoned call rate;

   c. Make oral interpretation services available free-of-charge to Covered Individuals in all non-English languages spoken by Covered Individuals; and

   d. Maintain the availability of service free-of-charge, such as TTY services or comparable services for the deaf and hard of hearing;

2. The Contractor must establish a schedule of intensive training for newly-hired and current customer service representatives about Medicaid and MassHealth benefits, customer service and motivational interviewing techniques and any other relevant training the Contractor deems necessary for staff to successfully engage with Members, including the Health Equity training requirements in **Section 2.20.D**.

D. Information for Covered Individuals and Potential Covered Individuals

The Contractor must, upon request, make available to Covered Individuals and Potential Covered Individuals in the Contractor's Plan information about:

1. The identity, locations, qualifications, and availability of Providers;

2. The rights and responsibilities of Covered Individuals including, but not limited to, those Covered Individual rights described in **Section 5.1.L**;

3. The procedures available to all Covered Individuals and Provider(s) to challenge or appeal the failure of the Contractor to provide a covered service and to appeal any Adverse Action as explained in the Covered Individual handbook;

4. How Covered Individuals and Potential Covered Individuals may access oral interpretation services free-of-charge in any non-English language spoken by Covered Individuals and Potential Covered Individuals;

5. How Covered Individuals and Potential Covered Individuals may access written materials in Prevalent Languages and Alternative Formats;

6. All BH Covered Services and non-BH Covered Services that are available to Covered Individuals either directly or through referral or authorization; and

7. Additional information that may be required by Covered Individuals and Potential Covered Individuals to understand the requirements and benefits of the Plan.

E. Website

The Contractor shall:

1. No later than two months prior to the Operational Start Date, develop and submit for EOHHS's approval a plan for a website containing information specifically related to the Contract.

2. Launch the website as of the Operational Start Date, and maintain it subject to EOHHS's approval.

3. Provide a link from the website to EOHHS's website, including, as further specified by EOHHS, a direct link to MassHealth supported provider directory.

4. Include, at a minimum, the following on its website:

   a. Culturally and linguistically competent information for Covered Individuals regarding services available through the BHP;

   b. A searchable BH Provider Network Directory that is updated at least monthly and as needed;

   c. As directed by EOHHS, a searchable PCC Plan Provider Directory for non-BH providers that is updated at least monthly and more frequently as needed;

   d. The BH Network Provider manual;

   e. The PCC Plan Provider handbook;

   f. The PCC Plan and PCACO Member handbooks;

   g. BHP-only handbook for Covered Individuals that are not enrolled in the PCC Plan or with a PCACO;

   h. Educational materials and links to evidence-based practices;

i. Information and materials to support integration between Network Providers and PCPs;

j. Community resources;

k. As directed by EOHHS, links to PCACOs, Community Partners, and other related websites; and,

l. Covered Services Lists.

5. Develop and propose to EOHHS within six months following the Contract Start Date a secure Provider and Covered Individual portal as part of the website.

6. Not provide any link to the Contractor's corporate website on any part of the website, unless agreed to by EOHHS.

7. Not provide any link to any type of corporate promotion on any part of the website.

8. Verify and certify to EOHHS on a quarterly basis the accuracy of all information contained on the website.

9. Data Gathering and Reporting Capacity in the Massachusetts Behavioral Health Access (MABHA) Website.

   a. Subject to further direction and specification by EOHHS, the Contractor shall collect and report data regarding any MassHealth Member waiting over 24 hours for a 24 Hour Level of Care Placement or on Administratively Necessary Days (AND) status in a 24 Hour Level of Care, as follows:

      1) The Contractor shall build and maintain a platform on the Massachusetts Behavioral Health Access (MABHA) website (the "MABHA Platform") to collect and manage the data;

      2) The Contractor shall report to EOHHS on Members awaiting placement within a 24-hour level of care or who are on Administratively Necessary Days (AND) status within a 24 hour level of care, respectively, as follows:

         a) Member-level reporting on a daily, weekly, and monthly basis;

         b) Aggregate reporting on a quarterly and annual basis; and

         c) Additional reporting in a form and frequency as requested by EOHHS on an ad hoc basis;

      3) The Contractor shall establish a process for CBHCs set forth in **Appendix A-3** to input data on individuals who receive services on

a fee-for-service basis or who have Third-Party Liability who are waiting over 24 hours for a 24 hour level of care into the MABHA Platform;

4) The Contractor shall establish a process for MassHealth managed care entities and others specified by EOHHS to input data on Members awaiting placement within a 24-hour level of care or who are on Administratively Necessary Days (AND) status within a 24 hour level of care into the MABHA Platform;

5) As directed by EOHHS, the Contractor shall create capacity for MassHealth managed care entities and others specified by EOHHS to view and print reports from the MABHA Platform in a manner allowable under federal and state privacy laws; and

6) The Contractor shall manage access of MassHealth managed care entities and others specified by EOHHS to the MABHA Platform at appropriate security levels.

b. The Contractor acknowledges and agrees that the data to be collected, managed, maintained, reported and otherwise used by the Contractor in developing and maintaining the MABHA website will include Protected Health information (PHI), as defined in 45 CFR §160.103, and other types of Personal Information (PI). The Contractor further acknowledges and agrees that in collecting, managing, maintaining, transmitting, disclosing and/or using such data for purposes of performing these activities. it is doing so in the capacity of EOHHS' Business Associate, as defined in 45 CFR §160.103, and is subject to, and shall comply with, all applicable terms, conditions and requirements set forth in **Section 5** hereof, including those relating to the Contractor's compliance with the Privacy and Security Rules as the Business Associate of EOHHS. Without limiting the generality of the foregoing, the Contractor agrees that the collection, management, maintenance and use of PI in and using the MABHA Platform shall comply with all applicable security requirements to which Contractor is subject, including those applicable under **Section 5** hereof.

10. Pursuant to Chapter 52 of the Acts of 2016 of the Massachusetts General Laws, Section 61, the Contractor shall post contact information for all insurance payers, including a phone number which is accessible 24 hours per day, for the purpose of enhancing communication between payers and providers.

Section 2.11 Marketing Activity Requirements

A. General Requirements

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

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

2. Comply with all applicable information requirements set forth in 42 CFR 438.10 when conducting Marketing activities and preparing Marketing Materials;

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

4. Comply with any requirement imposed by EOHHS pursuant to **Section 2.11.B** of this Contract;

5. Distribute and/or publish Marketing Materials statewide, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials where the campaign relates to a local event (such as a health fair) or to a single Provider (such as a hospital or clinic), to a certain zip code or zip codes; and

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

B. Permissible Marketing Activities

The Contractor may engage in only the following Marketing activities, in accordance with the requirements stated in **Section 2.11.A** above.

1. The Contractor may participate in a health fair or community activity sponsored by the Contractor provided that the Contractor shall notify all MassHealth-contracted Accountable Care Partnership Plans or MCOs within the geographic region of their ability to participate. Such notification shall be in writing and shall be made as soon as reasonably possible prior to the date of the event. If other MassHealth-contracted Accountable Care Partnership Plans or MCOs choose to participate in a Contractor's sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted Accountable Care Partnership Plans and MCOs. The Contractor may conduct or participate in Marketing at Contractor or non-Contractor sponsored health fairs and other community activities only if:

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

b. Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the Contractor's Plan.

2. The Contractor may participate in Health Benefit Fairs sponsored by EOHHS.

3. The Contractor may market to Covered Individuals by distributing and/or publishing Marketing Materials or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

a. Posting written Marketing Materials that have been pre-approved by EOHHS at Network or PCC Provider sites and other locations; and posting written promotional Marketing Materials throughout the state;

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

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

C. Prohibitions on Marketing and Enrollment Activities

The Contractor shall <u>not</u>:

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

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

a. The recipient of the Marketing Material must enroll in the Contractor's Plan, the PCC Plan, or a Primary Care ACO in order to obtain benefits or in order to not lose benefits; or

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

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

4. Seek to influence a Member's enrollment into the Contractor's Plan, the PCC Plan, or a Primary Care ACO in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts;

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

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

7. Conduct any Provider site Marketing, except as provided in **Section 2.11.B.3**;

8. Incorporate any costs associated with Marketing or Marketing incentives, or Non-Medical Programs or Services in the report specified in **Appendix E-1**; or

9. Engage in Marketing activities which target Members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.

D. Marketing Plan and Schedules

1. The Contractor shall make available to EOHHS, for review and approval upon request, a comprehensive Marketing plan, including proposed Marketing approaches, current schedules of all Marketing activities, and the methods, modes, and media through which Marketing Materials will be distributed.

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

3. The Contractor shall annually submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its Marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud Members or misrepresent the state, and are otherwise in accordance with the requirements of 42 CFR 438.104.

Section 2.12 Inquiries, Ombudsman Services, Grievances, and Appeals

A. General Requirements

The Contractor shall:

1. Maintain written policies and procedures for:

   a. The receipt and timely resolution of Grievances and Internal Appeals, as further described in **Section 2.12.B**, below. Such policies and procedures shall be approved by EOHHS; and

   b. The receipt and timely resolution of inquiries, where timely resolution means responding to the Inquiry at the time it is raised to the extent possible or, if not possible, acknowledging the inquiry within one business day and making best efforts to resolve the inquiry within one business day

of the initial inquiry. Such policies and procedures shall be approved by EOHHS.

2. Review the inquiry, Grievance and Internal Appeals policies and procedures established pursuant to **Section 2.12.B**, at least annually, to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS;

3. Create and maintain records of inquiries, Grievances, Internal Appeals, and BOH Appeals, using the health information system(s) specified in **Section 3.4**, to document:

    a. The type and nature of each inquiry, Grievance, Internal Appeal, and BOH Appeal;

    b. How the Contractor disposed of or resolved each Grievance, Internal Appeal, or BOH Appeal; and

    c. What, if any, corrective action the Contractor took.

4. Report to EOHHS annually regarding inquiries, Grievances, Internal Appeals and BOH Appeals, as described in **Appendix E-1**;

5. Assure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any inquiry, Grievance, Internal Appeal, or BOH Appeal;

6. Provide Covered Individuals with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes, as specified in **Section 2.12.B**; and

7. Pursuant to 42 CFR 438.414, provide the information specified in **Section 2.10.A.3.17** to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor.

8. In addition to other obligations set forth in this Contract related to Ombudsman Services, the Contractor shall support Covered Individual access to, and work with, the Ombudsman to address Covered Individual requests for information, issues, or concerns related to the Contractor by:

    a. Providing Covered Individuals with education and information about the availability of Ombudsman services including when Covered Individuals contact the Contractor with requests for information, issues, concerns, complaints, Grievances, Internal Appeals or BOH Appeals;

    b. Communicating and cooperating with Ombudsman staff as needed for such staff to address Covered Individual requests for information, issues, or concerns related to the Contractor, including:

1) Providing Ombudsman staff, with the Covered Individual's appropriate permission, with access to records related to the Covered Individual; and

2) Engaging in ongoing communication and cooperation with Ombudsman staff until the Covered Individual's request or concern is addressed or resolved, as appropriate, including but not limited to providing updates on progress made towards resolution.

B. Grievances and Internal Appeals

The Contractor shall maintain written policies and procedures for the filing by Covered Individuals or Appeals representatives and the receipt, timely resolution, and documentation by the Contractor of any and all Grievances and Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR Part 438, Subpart F. (For purposes of this Section, in cases where a minor is able, under law, to consent to a medical procedure, that a minor can request an appeal of the denial of such treatment, or may appoint an Appeal Representative to represent them, without parental/guardian consent.)

1. General Requirements

a. The Contractor shall put in place a standardized process that includes:

1) A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;

2) A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 2.12.B.2** below; and

3) A means for expedited resolution of Internal Appeals, as further specified in **Section 2.12.B.2.c.4**, when the Contractor determines (for a request from the Covered Individual) or a Provider indicates (in making the request on the Covered Individual's behalf or supporting the Covered Individual's request) that taking the time for a standard resolution, in accordance with **Section 2.12.B.2.c.3**, could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function.

b. The Contractor shall put in a place a mechanism to:

1) Accept Grievances filed either orally or in writing; and

2) Accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.12.B.2**, provided that if an Internal Appeal is filed orally,

the Contractor shall not require the Covered Individual to submit a written, signed Internal Appeal form subsequent to the Covered Individual's oral request for an appeal. Internal Appeals filed later than 60 days from the notice of Adverse Action may be rejected as untimely.

c. The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Covered Individuals and, if an Appeals representative filed the Grievance or Internal Appeal, to the Appeals representative and the Covered Individual within one business day of receipt by the Contractor.

d. The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.12.B.2**.

2. Notice of Adverse Action

The Contractor shall put in place a mechanism for providing written notice to Covered Individuals of any Adverse Action in a form approved by EOHHS as follows:

a. The notice must meet the language and format requirements specified in **Sections 2.10.A**.

b. The notice must explain the following:

1) The Adverse Action the Contractor has taken or intends to take;

2) The reason(s) for the Adverse Action, including the right of the Covered Individual to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Action, such as medical necessity criteria and processes, strategies, and standards related to the Adverse Action;

3) The Covered Individual's right to file an Internal Appeal or to designate an Appeal Representative to file an Internal Appeal on behalf of the Covered Individual, including exhausting the appeal process and right to file an appeal with the Board of Hearings;

4) The procedures for a Covered Individual to exercise his/her right to file an Internal Appeal;

5) The circumstances under which expedited resolution of an Internal Appeal is available and how to request it;

6) That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of the

review of an Internal Appeal if the Covered Individual submits the request for review within 10 days of the Adverse Action; and

7) That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of a BOH Appeal if the Covered Individual submits the request for the BOH Appeal within 10 days of receipt of notice of the Final Internal Appeal decision, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services.

c. The notice must be mailed within the following timeframes:

1) For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action in accordance with 42 CFR 431.211, except as provided in 42 CFR 431.213. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to five calendar days before the Date of Action if the Contractor has facts indicating that action should be taken because of probable fraud by the Covered Individual and the facts have been verified, if possible, through secondary sources.

2) For denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials of payment where coverage of the requested service is not at issue, which include, but are not limited to, denials for the following reasons:

a) Failure to follow prior authorization procedures;

b) Failure to follow referral rules; and

c) Failure to file a timely claim.

3) For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.6.C.2.c**, as expeditiously as the Covered Individual's health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days.

a) Extensions to the notice requirements outlined in **Section 2.12.B.2.c** above shall only be allowed if:

(i) The Provider, Covered Individual or Appeal Representative requests the extension; or

(ii) The Contractor can justify (to EOHHS, upon request) that the extension is in the Covered Individual's interest, and there is a need for additional information where there is a reasonable likelihood that the receipt of such information would lead to approval of the request, if received, and such outstanding information is reasonably expected to be received within 14 calendar days.

b) If the Contractor extends the timeframe, it must give the Covered Individual written notice of the reason for the extension and inform the Covered Individual of the right to file a Grievance if the Covered Individual disagrees with that decision issue and carry out its determination as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

4) For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.12.B.2.c**, as expeditiously as the Covered Individual's health requires but no later than 3 business days after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional days.

a) The extension shall only be allowed if:

(i) The Provider, Covered Individual, or Appeal Representative requests the extension; or

(ii) The contractor can justify (to EOHHS upon request) that the extension is in the Covered Individual's interest and there is a need for additional information where there is a reasonable likelihood that the receipt of such information would lead to approval of the request, if received and such outstanding information is reasonably expected to be received within 14 calendar days.

b) If the Contractor extends the timeframe, it must give the Covered Individual written notice of the reason for the extension and inform the Covered Individual of the right to file a Grievance if the Covered Individual disagrees with that decision issue and carry out its determination as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

5) For standard or expedited service authorization decisions not reached within the timeframes specified in **Sections 2.12.B.2.c.3 and 4**, whichever is applicable, on the day that such timeframes expire.

6) When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 2.9.B**, within one business day upon notification by the Covered Individual or Provider that one of the access standards in **Section 2.9.B** was not met.

3. Handling of Grievances and Internal Appeals

In handling Grievances and Internal Appeals, the Contractor shall:

a. Inform Covered Individuals of the Grievance, Internal Appeal, and BOH Appeal procedures, as specified in **Section 2.12.A**.

b. Give reasonable assistance to Covered Individuals in completing forms and following procedures applicable to Grievances and Internal Appeals, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

c. Provide notice of Adverse Actions as specified in **Section 2.12.B.2**;

d. Accept Grievances and Internal Appeals filed in accordance with **Section 2.12.B.1.b**;

e. Send written acknowledgement of the receipt of each Grievance or Internal Appeal to the Covered Individual and Appeal Representative within one business day of receipt by the Contractor;

f. Ensure that the individuals who make decisions on Grievances and Internal Appeals:

1) Are individuals who were not involved in any previous level of review or decision-making, and are not the subordinates of any such individuals; and

2) Take into account all comments, documents, records, and other information submitted by the Covered Individual or the Appeal Representative without regard to whether such information was submitted or considered in the Adverse Action determination.

g. Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

1) An appeal of a denial that is based on lack of medical necessity;

2) Grievances regarding the denial of a Covered Individual's request that an Internal Appeal be expedited, as specified in **Section 2.12.B.4.d.3**; and

3) Grievances regarding clinical issues;

h. Ensure that the following special requirements are applied to Internal Appeals:

1) The Contractor shall offer one level of review of an Adverse Action for Internal Appeals;

2) All reviews of Internal Appeals shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action;

3) The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and shall not require the Covered Individual or an Appeal Representative to confirm such oral requests in writing as specified in **Section 2.12.B.1.b.2**;

4) The Contractor shall provide a reasonable opportunity for the Covered Individual or an Appeal Representative to present evidence and allegations of fact or law, in person as well as in writing, and shall inform the Covered Individual or an Appeal Representative about the limited time available for this opportunity in the case of expedited Internal Appeals;

5) The Contractor shall provide the Covered Individual and an Appeal Representative, before and during the Internal Appeals process, the Covered Individual's case file, including medical records, and any other documentation and records considered, relied upon, or generated during the Internal Appeals process. This information shall be provided free of charge and sufficiently in advance of the applicable resolution timeframe; and

6) The Contractor shall include, as parties to the Internal Appeal, the Covered Individual and Appeal Representative or the legal representative of a deceased Covered Individual's estate;

4. Resolution and Notification of Grievances and Internal Appeals

The Contractor shall:

a. Dispose of each Grievance, resolve each Internal Appeal, and provide notice of each disposition and resolution, as expeditiously as the Covered Individual's health condition requires, within the following timeframes:

1) For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Covered Individual or the Covered Individual's Authorized Appeal Representative, unless this timeframe is extended in accordance with **Section 2.12.B.4.b**;

2) For standard resolution of Internal Appeals and notice to the affected parties, no more than 30 calendar days from the date the Contractor received either in writing or orally, whichever comes first, the Covered Individual request for an Internal Appeal unless this timeframe is extended under **Section 2.12.B.4.b**; and

3) For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours from the date the Contractor received the expedited Internal Appeal unless this timeframe is extended under **Section 2.12.B.4.b**. The Contractor shall process the expedited Internal Appeal even if a Provider is allegedly serving as the Covered Individual's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form. The Contractor shall require that the Provider submit a signed Authorized Appeal Representative form to the Contractor as documentation that the Covered Individual did in fact authorize the Provider to file the expedited Internal Appeal on the Covered Individual's behalf, as long as the expedited Internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

b. Extend the timeframes in **Section 2.12.B.4.a.1-3** by up to 14 calendar days if:

1) The Covered Individual or Appeal Representative requests the extension, or

2) The Contractor can justify (to EOHHS upon request) that:

a) The extension is in the Covered Individual'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;

3) For any extension not requested by the Covered Individual, the Contractor shall:

a) Make reasonable efforts to give the Covered Individual and Appeal Representative prompt oral notice of the delay;

b) Provide the Covered Individual and Appeal Representative written notice of the reason for the delay within 2 calendar days. Such notice shall include the reason for the extension of the timeframe and the Covered Individual's right to file a grievance; and

c) Resolve the appeal as expeditiously as the Covered Individual's health condition requires and no later than the date of extension expires.

c. Provide notice in accordance with **Section 2.12.B.4.a** regarding the disposition of a Grievance or the resolution of a standard Internal Appeal or an expedited Internal Appeal as follows:

1) All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10. For notices of an expedited Internal Appeal resolution, the Contractor shall also make reasonable efforts to provide oral notice to the Covered Individual; and

2) The notice shall contain, at a minimum, the following:

a) The results of the resolution process and the effective date of the Internal Appeal decision;

b) For Internal Appeals not resolved wholly in favor of the Covered Individual:

(i) The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing Form; and

(ii) That the Covered Individual will receive Continuing Services, if applicable, while the BOH Appeal is pending if the Covered Individual submits the appeal request to the BOH within 10 days of the Adverse Action, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services.

d. Resolve expedited Internal Appeals as follows:

1) The Contractor shall resolve Internal Appeals expeditiously in accordance with the timeframe specified in **Section 2.12.B.4.a.3** when the Contractor determines (with respect to an Enrollee's request for expedited resolution) or a Provider indicates (in making the request for expedited resolution on the Covered Individual's behalf or supporting the Covered Individual's request) that taking the time for a standard resolution could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall process the expedited Internal Appeal even if the Provider is allegedly serving as the Covered Individual's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form.

2) The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support a Covered Individual's Internal Appeal.

3) If the Contractor denies a Covered Individual's request for an expedited resolution of an Internal Appeal, the Contractor shall:

   a) Transfer the Internal Appeal to the timeframe for standard resolution in **Section 2.12.B.4.a.2** above;

   b) Make reasonable efforts to give the Covered Individual and Appeal Representative prompt oral notice of the denial, and follow-up within two calendar days with a written notice. Such notice shall include the Covered Individual's right to file a Grievance; and

   c) Resolve the appeal as expeditiously as the Covered Individual's health condition requires and no later than the applicable deadlines set forth in this Contract.

4) The Contractor shall not deny a Provider's request (on a Covered Individual's behalf) that an Internal Appeal be expedited unless the Contractor determines that the Provider's request is unrelated to the Covered Individual's health condition.

C. Board of Hearings

The Contractor shall:

1. Require Covered Individuals and their Appeal Representatives to exhaust the Contractor's Internal Appeals process before filing an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if either of the following conditions is met:

a. The Contractor has issued a decision following its review of the Adverse Action; or

b. The Contractor fails to act within the timeframes for reviewing Internal Appeals or fails to satisfy applicable notice requirements.

2. Include with any notice following the resolution of a standard Internal Appeal or an expedited Internal Appeal, as specified in **Section 2.12.B.4.c,** any and all instructive materials and forms provided to the Contractor by EOHHS that are required for the Covered Individual to request a BOH Appeal;

3. Notify Covered Individuals that:

a. Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services; and

b. It is the Covered Individual's or the Appeal Representative's responsibility to submit any request for a BOH Appeal to the BOH and to ensure that the BOH receives the request within the time limits, as specified in 130 CMR 610.015(B)(7), specifically 120 days after the Enrollee's receipt of the Contractor's Final Internal Appeal Decision where the Contractor has reached a decision wholly or partially adverse to the Covered Individual, provided however that if the Contractor did not resolve the Covered Individual's Internal Appeal within the time frames specified in this Contract and described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that Internal Appeal has expired.

4. Be a party to the BOH Appeal, along with the Covered Individual and their representative or the representative of a deceased Covered Individual's estate.

D. Additional Requirements

The Contractor shall:

1. For all Final Internal Appeal Decisions upholding an Adverse Action, in whole or in part, the Contractor shall provide EOHHS upon request, within one business day of issuing the decision, with a copy of the decision sent to the Covered Individual and Appeal Representative, as well as all other materials associated with such Appeal, to assist in EOHHS's review of the Contractor's determination. This requirement shall also apply to situations when the Contractor fails to act within the timeframes for reviewing Internal Appeals. For decisions involving Behavioral Health Services, EOHHS may consult with the Deputy Commissioner of the Department of Mental Health in its review of the Contractor's decision;

2. Upon learning of a hearing scheduled on a BOH Appeal concerning such a Final Internal Appeal Decision, notify EOHHS immediately and include the names of the Contractor's clinical and other staff who will be attending the BOH hearing;

3. Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;

4. Submit all applicable documentation to the BOH, EOHHS, the Covered Individual and the designated Appeal Representative, if any, within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of the notice of Adverse Action, any documents relied upon by the Contractor in rendering the decision resolving the Internal Appeal, and any and all documents that will be relied upon at hearing;

5. Make best efforts to ensure that a Provider, acting as an Appeal Representative, submits all applicable documentation to the BOH, the Covered Individual and the Contractor within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be relied upon at the hearing;

6. Comply with and implement the decisions of the BOH;

7. In the event that the Covered Individual appeals a decision of the BOH, comply with and implement the decisions of any court of competent jurisdiction; and

8. Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:

    a. Determine whether each Covered Individual who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 2.12.C.1**;

    b. If requested by the Covered Individual, assist the Covered Individual with completing a request for a BOH Appeal;

    c. Receive notice from the BOH that a Covered Individual has requested a BOH Appeal, immediately notify EOHHS, and track the status of all pending BOH Appeals;

    d. Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH Appeal was timely received, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Service;

e. Instruct Covered Individuals for whom an Adjustment has been made about the process of informing the BOH in writing of all Adjustments and, upon request, assist the Covered Individual with this requirement, as needed;

f. Ensure that the case folder and/or pertinent data screens are physically present at each hearing;

g. Ensure that appropriate Contractor staff attend BOH hearings;

h. Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;

i. Upon notification by BOH of a decision, notify EOHHS immediately;

j. Ensure that the Contractor implements BOH decisions upon receipt;

k. Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;

l. Coordinate with the BOH, as directed by EOHHS; and

m. Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.

9. Provide information about the Contractor's grievances and appeals policies to all Providers and Material Subcontractors at the time the Contractor and these entities enter into a contract; and

10. Maintain records of Grievances and Appeals in a manner accessible to EOHHS, available to CMS upon request, and that contain, at a minimum, the following information:

a. A general description of the reason for the Appeal or Grievance;

b. The date received, the date of each review, and, if applicable, the date of each review meeting;

c. Resolution of the Appeal or Grievance, and date of resolution; and

d. Name of the Covered Individual for whom the Appeal or Grievance was filed.

E. Continuing Services

The Contractor shall:

1. Comply with the provisions of 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Covered Individual specifically indicates that he or

she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service;

2. Provide Continuing Services until one of the following occurs:

   a. The Covered Individual withdraws the Internal Appeal or BOH Appeal; or

   b. The BOH issues a decision adverse to the Covered Individual;

3. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Internal Appeal or BOH Appeal were pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Covered Individual's health condition requires but no later than 72 hours from the date it receives notice reversing the determination; and

4. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services and the Covered Individual received Continuing Services while the Internal Appeal or BOH Appeal were pending, the Contractor shall pay for such services.

Section 2.13 Quality Management and Quality Improvement

A. Comprehensive QM/QI Program

The Contractor shall implement a comprehensive Quality Management (QM) and Quality Improvement (QI) program that includes ongoing quality assessment and performance improvement of all areas of the Contractor's responsibility under this Contract.

The QM and QI program shall:

1. Assess the quality and appropriateness of care and services furnished to all Covered Individuals, including Covered Individuals with special health care needs;

2. Focus on improving the Covered Individual's health status through the delivery of high quality and cost-effective care, and by the provision of programmatic supports that foster a high level of communication and cooperation among medical and Behavioral Health care providers, with regard to the Covered Individuals they are serving;

3. Incorporate QM and QI principles into all aspects of the operation of the Contract;

4. Be based upon robust data collection, accurate measurement, and data analysis that enhance Behavioral Health service delivery; the integration of care delivered by medical and Behavioral Health care providers; and Covered Individual health outcomes;

5. Include the conducting of biennial Member satisfaction surveys and providing EOHHS with written results of such surveys:

6. Include effective assessment of healthcare disparities and strategies to identify and address variations related to health care access and health outcomes; and

7. Include activities, resources and strategies that support improved clinical outcomes for Covered Individuals that improve function and symptom management.

B. QM/QI Program Structure

The Contractor shall:

1. Establish a set of QM/QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QM/QI initiatives and for the completion of QM/QI initiatives in a competent and timely manner;

2. Ensure that such QM/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;

3. Establish internal processes to ensure that the QM activities for Behavioral Health Services reflect utilization across the Network and include all of the activities in this Section of this Contract and, in addition, the following elements:

   a. A process to utilize HEDIS results in designing QM/QI activities;

   b. A medical record review process for monitoring Network Provider 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;

   c. A process to measure Network Providers and Covered Individuals, 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;

   d. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;

   e. A process for including Covered Individuals and their families in Quality Management activities, as evidenced by participation in Covered Individual and family advisory councils;

f. In collaboration with and as further directed by EOHHS, a plan to monitor Intensive Care Coordination and Family Training and Support Services according to fidelity measures that are consistent with national Wraparound standards;

1) In collaboration with and as further directed by EOHHS, a process to monitor the quality of all Behavioral Health services, including using tools such as the MA DRM (Document Review Measure), or another tool approved by EOHHS, to evaluate the adequacy of medical record keeping for both Intensive Care Coordination and In-Home Therapy Services. The Contractor shall apply the approved quality assessing tool at least annually on a mix of Intensive Care Coordination (ICC) and In- Home Therapy (IHT) Services provided. Unless otherwise directed by EOHHS, the Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Covered Individuals who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 100 Covered Individuals' medical files per Contract Year; and

4. Have in place a written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor's QM/QI initiatives.

C. Quality Improvement Projects

1. Development of QIPs

a. The Contractor shall annually develop and propose to EOHHS a minimum of five quality improvement projects (QIPs) to be incorporated into the Contract each year.

b. The Contractor shall design Quality Improvement Projects (QIPs) to achieve significant improvement in clinical care and non-clinical care areas that have a favorable effect on health outcomes and Covered Individual satisfaction. Such QIPs shall be designed as ongoing interventions, sustained over time and shall be targeted to areas that present significant opportunities for performance improvement.

c. The QIPs shall be based on the Contractor's actual experience serving Covered Individuals, the findings of the assessments required in **Section 2.13.F**, or direction from EOHHS. The Contractor also may identify other areas, such as those internal to the Contractor's operation, for inclusion in quality improvement projects.

d. Data sources for the design of the QIP may include without limitation:

1) critical incident (Reportable Adverse Incident) reports;

2) continuing care after discharge from one Level of Care to another, community tenure, and recidivism rates;

3) Grievances and Internal Appeals and other feedback from Covered Individuals;

4) Provider concerns;

5) medical record reviews;

6) Provider waiting lists;

7) Covered Individual and Provider satisfaction/experience surveys;

8) direction from EOHHS and DMH related to agencies' goals;

9) data related to PCC Plan Management Support Services activities;

10) the Care Management Program; and

11) data relative to the Contractor operations, such as Claims processing time frames and telephone response time.

e. The proposed QIPs may include administrative service, quality, and program development goals, although no more than two projects may address administrative services.

f. Each proposed QIP shall incorporate a project statement that includes highly specified and measurable goals and objectives, methodology, as well as detailed metric calculation specifications.

g. For each QIP, the Contractor shall develop a work plan for completion of the project including time frames by which the Contractor must demonstrate that the goals of the project have been achieved.

h. At least two of the five QIPs the Contractor proposes shall be as described in **Section 2.13.F.5** that satisfy the requirements of 42 CFR 438.240(b) and (d). EOHHS's External Quality Review (EQR) vendor shall validate the Contractor's performance of these quality improvement projects. Current listing of BH priority area standard goals including performance measures and quality improvement project initiatives is in **Appendix G**.

i. Should EOHHS and Contractor be unable to reach agreement on the improvement projects and/or the measures, EOHHS shall establish the improvement projects and/or measures.

2. Management of the QIPs

a. The Contractor shall designate relevant QM staff to meet with EOHHS twice a year to review operational issues, milestones and initiatives, as well as progress toward the QIPs, in Contract status meetings.

b. The Contractor shall evaluate the outcome of the QIPs and present its findings to EOHHS in the forms and time frames agreed to by EOHHS.

c. If EOHHS determines that the Contractor is not in compliance with the requirements for proposed annual QIPs, the Contractor shall prepare and submit a corrective action plan to EOHHS for review and approval.

D. Data Management

The Contractor's QM program shall be informed by consistent utilization and analysis of data, incorporating at least the following elements:

1. A process for collecting, analyzing and managing with utilization, clinical and outcomes data to improve Covered Individuals' health outcomes;

2. A process for collecting and submitting performance measurement data in accordance with 42 CFR 438.330;

3. A process for tracking to resolution areas targeted for QI as identified by the Contractor, EOHHS or CMS;

4. Using multiple data sources and drawing conclusions based on data to drive system improvement through evidence-based practices, Practice Guidelines, and other data-driven clinical initiatives.

E. NCQA Accreditation

1. If the Contractor is NCQA accredited as a Health Plan/MCO or as an MBHO (Managed Behavioral Healthcare Organization) for its Medicaid product covered by this Contract as of the Operational Start Date of this Contract, the Contractor shall maintain full NCQA accreditation pursuant to the requirements of NCQA throughout the term of this Contract.

2. If the Contractor does not have such NCQA accreditation for its Medicaid product covered by this Contract as of the Operational Start Date, the Contractor shall attain such interim and then full accreditation within time frames determined acceptable by EOHHS and consistent with current NCQA accreditation requirements.

a. The Contractor's application for interim and full NCQA accreditation shall be submitted at the earliest point allowed by NCQA. The Contractor shall provide EOHHS with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.

b. Once accredited, the Contractor shall maintain full NCQA accreditation pursuant to the requirements of NCQA throughout the term of this Contract.

3. The Contractor shall authorize NCQA to provide EOHHS a copy of its most recent accreditation review for its Massachusetts plan(s), including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings; and expiration date of accreditation.

4. The Contractor shall provide EOHHS with updates of its NCQA accreditation status at least annually, whenever if there are any changes within the accreditation period, and upon request by EOHHS.

5. If the Contractor achieves provisional accreditation status from NCQA EOHHS shall require the Contractor to initiate a corrective action plan within thirty (30) calendar days of receipt of the Final Report from NCQA and work to address the findings contributing to the provisional accreditation status.

6. The Contractor's failure to attain full NCQA accreditation as a managed care plan for its Medicaid product covered by this Contract or its failure to maintain full NCQA accreditation at any time, may be considered a breach of the Contract and may result in termination of the Contract.

F. QM Plan for Behavioral Health Management

On an annual basis, the Contractor shall create and implement a single, comprehensive Quality Management plan that defines the QM program, details the Contractor's quality activities and provides for self-assessment of the Contractor's responsibilities under the Contract.

1. The Contractor shall submit such QM plan for EOHHS review and approval by January 31st of each Contract Year.

2. The QM plan for the first year of the Contract shall focus on the establishment of baselines and benchmarks for use in setting and assessing health improvement targets and quality improvement goals in subsequent years of the Contract.

3. The QM plan shall include activities, measures, and performance improvement projects that are specifically relevant to CBHCs, ASD/ID for MCPAP and EC MCPAP.

4. The QM plan shall describe planned improvement activities related to:

a. The Contractor's management of the BH services provided to Covered Individuals;

b. The Contractor's Management Support Services for the PCC Plan;

c. The Contractor's efforts to improve care integration across medical and Behavioral Health care services; and

d. The Contractor's Care Management Program.

5. Each year's proposed QM plan shall be informed by an assessment of prior years' activities and results through an annual retrospective report, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year. The annual QM plan shall include but not be limited to:

a. Monitoring of the following performance indicators, at a minimum, and others as directed by EOHHS. If the results of the performance indicator(s) meet or exceed the benchmark, the Contractor shall continue to monitor the indicator(s); if the results of the performance indicator(s) fall below the benchmark, the Contractor shall implement a Quality Improvement Program (QIP) as directed by EOHHS. Performance Indicators shall, at a minimum:

1) Assess whether qualified and clinically appropriate Network Providers are available to provide BH Covered Services, and the degree to which the Provider Network met the needs of Covered Individuals for:

a) access within the access standards required by the Contract;

b) access within different geographic areas across the Commonwealth;

c) access to individuals with physical disabilities;

d) ability to communicate, either directly or through a skilled interpreter, with a Covered Individual in his/her primary language; and

e) ability to address Covered Individuals' health disparity needs.

2) Assess Network Providers' success at communicating with Primary Care Practitioners, when appropriate.

3) Assess the development of the Behavioral Health service delivery system, including overuse, underuse and misuse of services; special measures shall be developed and implemented to highlight Provider best practices.

4) Assess and measure of utilization reviewers' consistency in applying Medical Necessity criteria in UM activities and in the medical record (chart) review process.

5) Assess and summarize critical incidents reported by Network and non-Network Providers, including actions taken in response.

6) Assess the subjects and outcomes of Appeals, Grievances and complaints, including timeframes required to reach resolution, and opportunities for improvement.

7) Consistent with NCQA accreditation requirements, assess Covered Individual, Network Provider and PCC satisfaction through administration of satisfaction surveys.

b. Timelines, objectives and goals for improvement projects and activities, including clinical and non-clinical activities as well as those BH improvement projects generated by the quality improvement (QI) goals as required by EOHHS. The projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Covered Individual, Network Provider and PCC satisfaction. The performance improvement projects must involve the following:

1) measurement of performance using objective indicators of quality;

2) implementation of system interventions to achieve improvement in quality;

3) evaluation of the effectiveness of the interventions; and

4) planning and initiation of activities for increasing or sustaining improvement.

The Contractor must complete each project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. The Contractor must report and present the status and results of each project to EOHHS at least twice a year, and as requested.

c. Analysis of the effectiveness of treatment services, employing standard measures of symptom reduction/management as well as measures of functional status and recovery. The Contractor shall recommend to EOHHS an approach to meet this requirement, including the assessment instrument, or scale, to be used and the methodology for its application. EOHHS reserves the right to approve or specify the instrument(s) and analysis methodology to be used.

d. Administration no less often than biennially of satisfaction surveys to Covered Individuals.

e. Administration no less often than biennially of Network Provider satisfaction surveys, with results stratified by provider type and specialty.

f. Administration biennially of PCC satisfaction surveys with results stratified by provider type and specialty.

G. Quality Management Plan for PCC PMSS

1. Comprehensive Quality Management plan

The Contractor shall create and implement a single, comprehensive Quality Management plan, containing the same elements as described in **Section 2.13.F**, that reflects the Contractor's organizational QM philosophy and structure and includes PCC Plan Management Support Services-related activities. Such QM plan shall be submitted to EOHHS for review and approval by January 31st of each Contract Year. This component of the QM plan shall describe planned improvement projects and activities, including but not limited to:

a. Timelines, objectives and goals for the planned improvement projects and activities, including clinical and non-clinical initiatives;

b. A process for monitoring data for, and tracking to resolution, areas targeted for quality improvement (QI) as identified by the Contractor or EOHHS;

c. A process for comparing QI project results against established goals;

d. Plans for coordinating medical and Behavioral Health care services;

e. A process for monitoring PCCs' ability to manage the health care needs of culturally diverse PCC Plan Enrollees;

f. A process to evaluate annually the effectiveness of QM plan activities and, based on the results, to identify and implement improvement activities;

g. An annual retrospective QM activities report based on the previous year's QM plan, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year, beginning with January 2024.

H. Provider and PCC Quality Forums

The Contractor shall:

1. Annually organize and conduct at least two quality forums, as follows:

a. The quality forums shall be held through a webinar at a variety of times convenient to PCCs, Network Providers and other providers as directed by EOHHS. Some or all of the forums may also be held at locations throughout the state, in comfortable environments that encourage PCCs,

Network Providers and other providers as appropriate to attend, and including refreshments (food and non-alcoholic beverages) as part of the event.

b. The quality forums shall be offered on topics that primarily focus on EOHHS goals, quality improvement, increased coordination and collaboration of medical and Behavioral Health care services, or improved service delivery and health outcomes for Covered Individuals.

2. Submit to EOHHS for review and approval a proposal for the quality forum topics for each Contract Year at least 90 days prior to the start of the Contract Year. For the first Contract Year, at least one quality forum must include Health Equity and CLAS topics consistent with requirements in **Section 2.20**. EOHHS may require the Contractor to conduct quality forums on topics of EOHHS's choosing.

3. Develop the content of each quality forum in collaboration with EOHHS and key stakeholders.

4. Implement a mechanism for attendees and the Contractor to evaluate the quality forums and identify areas for improvement and, with EOHHS's approval, incorporate such improvements into future quality forums.

5. Obtain the required approval to offer and grant continuing medical education, risk management, and continuing education units to participants.

6. Within 30 days after the last session of a quality forum series, provide EOHHS a summary report on the forum series which shall include, at a minimum, information on the number and type of attendees (profession and practice name), the location, the presentation topic and responses from attendees regarding the quality of the program presented.

Section 2.14 Data Management, Information Systems, and Reporting Requirements

A. General Requirements

The Contractor shall:

1. Maintain information systems (Systems) that will enable the Contractor to meet all of EOHHS's requirements as outlined in this Contract, as described in this Section and as further directed by EOHHS.

2. Accept all Contract-related files and data delivered by EOHHS, in the format specified by EOHHS.

3. Ensure a secure, HIPAA-compliant exchange of information on Covered Individuals and Uninsured Individuals and persons with Medicare only, as applicable, between the Contractor and EOHHS and any other entity EOHHS deems appropriate. Such files shall be transmitted to EOHHS through secure FTP,

HTS, or a similar secure data exchange as determined by EOHHS. The Contractor shall align its HIPAA Companion Guide for its Network Providers with the MassHealth Companion Guide for Providers.

4. Develop and maintain a website that is accurate, up-to-date, and designed in a way that enables Covered Individuals and Providers to quickly and easily locate all relevant information, as specified by EOHHS. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website(s).

5. Cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS.

6. Actively participate in any EOHHS Systems Workgroup or other workgroups, as directed by EOHHS. The workgroup shall meet in the location and on a schedule determined by EOHHS.

B. Member Eligibility System Requirements

The Contractor shall ensure that its enrollment system performs, at a minimum, the following functions:

1. On each business day, obtains from EOHHS by electronic communications link and immediately updates its database with all information pertaining to all Covered Individual enrollments.

2. Uniquely identifies each Covered Individual, and includes in the Contractor's data system information provided by the EOHHS eligibility feed regarding the Covered Individual's state agency affiliations, PCACO or PCC Plan enrollment, PCC, and TPL status. This information must also be incorporated into the Contractor's clinical Information Systems. The Contractor must use the EOHHS-assigned MID as the Covered Individual identifying number.

3. On each business day receives and processes an electronic file of EOHHS's MID merges.

4. On each business day, receives from EOHHS by electronic communications link and processes information pertaining to all disenrollments.

5. Once a month receives and processes a copy of EOHHS's carrier file, including carrier codes, and uses this file to reconcile the Contractor's cost avoidance and recovery activities.

6. Once a month receives a list of EOHHS's PCCs and tracks the accuracy of information on PCCs if directed to do so by EOHHS.

7. Receives and processes on a quarterly basis, or as otherwise agreed to by EOHHS, a file containing a list of all Covered Individuals, by MID, Plan Type

and effective dates, and uses this file to reconcile the Contractor's Covered Individual enrollment file with EOHHS data.

C. Automated Service Authorization

The Contractor shall employ an automated service authorization system that supports the service authorization requirements and procedures in **Section 2.6.C** and provides for the documentation of at least the following information for each Covered Individual:

1. Identifying demographic information;
2. Identification of Provider delivering service, including his/her national provider identifier (NPI);
3. Diagnosis code(s);
4. Authorized service units.

D. Claims Processing Requirements

The Contractor shall ensure that its Claims processing system performs, at a minimum, the following functions:

1. Maintains a unique Provider identification number for each Provider and utilizes the NPI for purposes of billing.
2. Accepts Claims submitted by Network Providers or their designated representative(s). The Contractor shall:
    a. Accept national UB-04 and national CMS 1500 electronic formats;
    b. Accept paper-based Claims using standardized forms.
3. Adjudicates Claims and issues payment for approved Claims once a week, at a minimum.
4. Adjudicates and issues payment for all Clean Claims within 30 days of receipt of the Clean Claim.
5. Provides policies and procedures that track all Claims from point of receipt to final disposition, in order to ensure that all invoices and electronic media Claims are processed to completion and have not been previously paid.
6. Creates payment and HIPAA 835 remittance advices for each Provider for Claims activities during a current cycle. The system specifications and file layout must:
    a. Identify each Claim in a cycle and its status, including a description of all errors and denial reasons; and
    b. Generate the remittance advices in electronic or paper format, as appropriate for each Provider.

7. Collects and maintains Network Provider financial data and issues state and federal income tax documents in accordance with state and federal law. This shall include, at a minimum, TIN/FEIN and NPI.

8. Maintains all Claims files and records in accordance with all applicable laws, and submits them to EOHHS, the Commonwealth or federal agencies, as needed and upon request.

9. Ensures that security controls are in accordance with current industry standards and relevant CMS policy.

10. Ensures confidentiality of all data in accordance with state and federal laws and regulations, including 42 CFR 431, Subpart F, implementing procedures to properly safeguard and dispose of data. (See also **Section 5.2**.)

E. Encounter Data

The Contractor shall collect, manage, and report Encounter Data as described in this Section and as further specified by EOHHS. The Contractor shall:

1. Collect and maintain 100% Encounter Data for all Behavioral Health Covered Services provided to Covered Individuals and Uninsured Individuals, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data;

2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;

3. Upon request by EOHHS, or its designee, provide medical records of Covered Individuals and a report from administrative databases of the Encounters of such Covered Individuals in order to conduct validation assessments. Such validation assessments may be conducted annually;

4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include, but is not limited to, the data elements described in **Appendix D**, the delivering physician, and elements and level of detail determined necessary by EOHHS. As directed by EOHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the Servicing/Rendering, Referring, Prescribing and Primary Care Provider, and any National Drug Code (NDC) information on drug claims. As directed by EOHHS, such Encounter Data shall also include information related to denied claims and 340B Drug Rebate indicators on drug claims, if applicable;

5. Provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes,

rules, regulations and guidance. The Contractor shall submit Encounter Data by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix D**;

6. Submit Encounter Data that is at a minimum compliant with the standards specified in **Appendix D**, including but not limited to the standards for completeness and accuracy. To meet the completeness standard, all critical fields in the data must, at a minimum, contain valid values. To meet the accuracy standard, the Contractor must, at a minimum, have systems in place to monitor and audit claims. The Contractor must also correct and resubmit denied encounters as necessary;

7. Ensure that all EPSDT screens, including Behavioral Health screenings, are explicitly identified in the Encounter Data in accordance with this **Section 2.14.E**;

8. Ensure that all initial Behavioral Health Clinical Assessments are explicitly identified in the Encounter Data submitted in accordance with this **Section 2.14.E**;

9. If EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not compliant with the benchmarks described in **Appendix D-1** the Contractor shall:

    a. Notify 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 EOHHS approval, within a time frame established by 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 EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

    d. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is compliant with the standards described in **Appendix D**. The Contractor may be financially liable for such validation study;

10. Submit any correction/manual override file within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix D**;

11. 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;

12. EOHHS may, at any time, modify the specifications required for submission of Encounter Data, including but not limited to requiring the Contractor to submit additional data fields to support the identification of Covered Individuals' affiliation with their Primary Care Provider;

13. At EOHHS' request, the Contractor shall submit denied claims, as further specified by EOHHS;

14. EOHHS may impose an intermediate sanction in accordance with **Section 5.3.L** in the event that Contractor's submitted Encounter Data does not meet the completeness, accuracy, timeliness, form, format, and other standards described in this Section;

15. At a time specified by EOHHS, the Contractor shall comply with all Encounter Data submission requirements related to HIPAA and the ASCX12N 837 format. This may include submitting Encounter Data to include professional, institutional and dental claims and submitting pharmacy claims using NCPDP standards. This submission may require the Contractor to re-submit Encounter Data previously supplied to EOHHS in alternative formats.

F. Design Requirements

The Contractor shall:

1. Comply with EOHHS requirements, policies and standards in the design and maintenance of its Information Systems in order to successfully meet the requirements of this Contract.

2. Ensure that its Information Systems interface with and are compliant with EOHHS's MMIS, the EOHHS Virtual Gateway, and other EOHHS IT architecture that EOHHS identifies.

3. Have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files including HIPAA transaction files, as specified on the 820 Companion Guide, 834 Outbound Companion Guide available at: https://www.mass.gov/lists/masshealth-hipaa-companion-guides.

4. Interface files in the Contract include but are not limited to:

    a. HIPAA 834 History Request File

b. HIPAA 834 Outbound Daily File

c. HIPAA 834 Outbound Full File

d. HIPAA 834 History Response

e. HIPAA 820

5. Have the ability to receive and analyze data from the EOHHS Data Warehouse regarding medical and pharmacy Claims, as provided by EOHHS.

6. Conform to HIPAA-compliant standards for data management and information exchange.

7. Implement controls to maintain information security and integrity.

8. Maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS. These processes may be reviewed by EOHHS upon request.

9. Collaborate with EOHHS to verify its compliance with Version 5010 standards during the readiness review period prior to the Operational Start Date.

10. Use Version 5010 standards for HIPAA electronic health care transactions, including claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions.

11. Implement Version 5010 standards and framework for the most recent version of medical data code sets (e.g., ICD-11-CM and ICD-11-PCS).

12. Ensure that an automated health information system (HIS) to support all of the Contractor's responsibilities under the Contract is operative as of the Operational Start Date and remains operative for the duration of the Contract, unless otherwise directed or agreed to by EOHHS. The HIS must achieve the objectives of 42 CFR Part 438, Subpart D and shall collect, analyze, integrate and report data, including but not limited to information regarding:

    a. Service authorizations;

    b. Utilization;

    c. Inquiries, Grievances, Internal Appeals, and BOH Appeals;

    d. Disenrollments for reasons other than for loss of MassHealth eligibility;

    e. Claims;

    f. Provider information;

    g. Services furnished to Covered Individuals through an Encounter data system, as specified in **Section 2.14.E**;

h. Covered Individual characteristics, including but not limited to race, ethnicity, spoken language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheelchair dependence, and characteristics gathered through Contractor contact with Covered Individuals, e.g., through the Care Management Program, Behavioral Health Clinical Assessments, or other reliable means;

i. Enrollee participation in the Care Management Program; and

j. Identification of Covered Individuals as belonging to any of the special populations or subgroups identified through provision of clinical services.

13. Ensure that data received from Providers is 99 percent complete and 95 percent accurate by:

a. Verifying the accuracy and timeliness of reported data;

b. Screening the data for completeness, logic and consistency;

c. Establishing a remediation process for data that is deemed inaccurate during verification and screening; and

d. Collecting service information from Providers, in standardized formats to the extent feasible and appropriate or as directed by EOHHS, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

14. Make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(3).

15. Utilize its HIS to pay Network Providers for BH Covered Services rendered to Covered Individuals, and ESP, AMCI, and YMCI services as directed by EOHHS, rendered to Uninsured Individuals, including persons covered by Medicare only, in accordance with the Contractor's service authorization, Claims processing, enrollment and disenrollment procedures, and data handling and administrative billing requirements.

16. As set forth in 42 CFR 438.242(b)(1), comply with Section 6504(a) of the Affordable Care Act.

G. System Access Management and Information Accessibility Requirements

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

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

H. System Availability and Performance Requirements

1. The Contractor shall ensure that its Covered Individual and Provider web functions and phone-based functions are available to Covered Individuals and Providers 24 hours a day, seven days a week. At a minimum, these functions shall be available 99.9% of the month.

2. The Contractor shall draft an alternative plan that describes access to Covered Individual and Provider information in the event of Information System failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) (see **Section 2.3.C.4**) and shall be updated annually and submitted to EOHHS upon request. In the event of Information System failure or unavailability, the Contractor shall notify EOHHS upon discovery, and implement the COOP immediately.

3. The Contractor shall preserve the integrity of Covered Individual-sensitive data whether active or archived.

I. Virtual Gateway

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

1. Submit all specified information, including but not limited to invoices, Contract or other information to EOHHS through these web-based applications;

2. Comply with all applicable EOHHS policies and procedures related to such services;

3. Use all business services through the EOHHS Virtual Gateway, as required by EOHHS;

4. Take necessary steps to ensure that the Contractor and its subcontractors or affiliates have the ability to access and utilize all required web-based services; and

5. Execute and submit all required agreements, including subcontracts, agreements, memorandums of understanding, confidentiality and/or end user agreements in connection with obtaining necessary end user accounts for any Virtual Gateway business service.

J. Telephone System

1. General Requirements

As of the Operational Start Date, the Contractor shall:

a. Maintain the telephone number (800-495-0086), with telecommunications device for the deaf (TDD) and teletypewriter (TTY) transmission and reception capability for the deaf and hearing-impaired, as the Contractor's toll-free number, unless otherwise agreed to by EOHHS.

b. Provide access through the toll-free number to Member and Provider Customer Service representatives via dedicated menu option(s).

c. Maintain a telephone system that performs the following functions:

1) Assigns priority status to Covered Individuals in crisis to ensure immediate response from a clinician staffing the Clinical Referral and Service Authorization line;

2) Provides a sufficient number of telephone lines and trunks to handle all incoming calls so that no caller receives a busy signal;

3) Provides a means for callers to leave messages for the Contractor after business hours, and ensures that such calls are handled by the next business day; and

4) Allows the Contractor to directly connect the caller to other agencies or contractors, as specified by EOHHS.

d. Develop, implement, maintain and enhance, as necessary, a call management system for Clinical Authorization and Referral and Member and Provider Customer Service calls that:

1) Records and tracks all calls handled, to include the following information:

a) name of caller and Covered Individual, Provider or PCC identification number, where applicable;

b) call date and time;

c) reason for the call;

d) disposition of the call, including whether the matter was resolved at the time of first contact if a complaint, was resolved by the end of the next business day, or if the call is pending resolution; and

e) if the call is pending resolution, additional information to assist in the escalation and resolution of outstanding issues.

2) Tracks Covered Individual call volume by PCC, DYS, DCF, TPL, etc.; and

3) Provides service representatives with online access to relevant information from previous calls.

e. Arrange for appropriate telephone listings of the Contractor, as approved by EOHHS, to be submitted for publication at least one month prior to the Operational Start Date.

f. Periodically, and as directed by EOHHS, evaluate the effectiveness of the Provider and Member Customer Services telephone system, and submit proposals for improvement to EOHHS.

2. Telephone Response Requirements

The Contractor shall ensure that:

a. Calls from Covered Individuals in crisis are handled immediately by a staff clinician;

b. For each line, including Clinical Referral and Service Authorizations, Member and Provider Customer Service and PCC Hotlines, staff make best efforts to answer all calls from Covered Individuals and Providers and PCCs within 30 seconds of when callers select the menu option for the line they are trying to reach; but in no case shall fewer than 90 percent of these calls be answered within 30 seconds;

c. Calls to all lines have an abandoned call rate of less than 5 percent; and

d. Calls to each specific line are answered within the specified time frames by the appropriate staff:

1) Calls to clinical lines are answered by a clinician;

2) Calls to Customer Service are answered by customer service staff; and

3) Calls to the PCC Hotline are answered by trained and dedicated Provider service representatives.

K. Medical Records

The Contractor shall:

1. Comply with, and require Network Providers to comply with, all state and federal statutory and regulatory requirements applicable to medical records, including the requirements set forth in 130 CMR 130 CMR 433.409, 130 CMR 450.205, 42 CFR 456.111 and 42 CFR 456.21 (if applicable), and any amendments thereto. In addition, all medical records, whether paper or electronic shall, at a minimum:

a. Be maintained in a manner that is current, detailed, and organized and that permits effective patient care and quality review;

b. Include sufficient information to identify the Covered Individual, date of encounter and pertinent information that documents the Covered Individual's diagnosis;

c. Describe the appropriateness of the treatment and services, the course and results of the treatment and services; and

d. Be consistent with current and nationally accepted professional standards for providing the treatment/services, as well as systems to accurately document the following:

1) Covered Individual information including, among other things, primary language spoken;

2) Clinical information;

3) Behavioral Health Clinical Assessments;

4) Treatment plans;

5) Treatment or services provided;

6) Contacts with Covered Individuals' family, guardians, or significant others; and

7) Treatment goals and outcomes;

8) All contacts with state agencies, as applicable; and

9) Pharmacy records.

2. Comply with, and require Network Providers to comply with, all state and federal statutory and regulatory requirements applicable to confidentiality of medical records, including but not limited to M.G.L. c. 66A and, if applicable, M.G.L. c. 123 § 36, 104 CMR 27.17, and 104 CMR 28.09.

3. Provide EOHHS with a copy of any Covered Individual's medical records, in general within 10 days of EOHHS's request; except that EOHHS may allow the Contractor up to one month from the date of EOHHS's initial request to produce such records if the Contractor has made best efforts to produce them in the specified time and EOHHS reasonably determines that the need for such record(s) is not urgent.

4. Conduct medical record audits periodically and at the request of EOHHS. Such audits may be subject to validation by EOHHS or its agent.

L. Reports and Notifications

1. General

a. The Contractor shall provide and require its Material Subcontractors and other subcontractors to provide, in accordance with the timelines, definitions, formats and instructions contained herein or as further specified by EOHHS:

1) All information required under this Contract, including but not limited to, the requirements of **Appendix E** or other information related to the performance of its or their responsibilities hereunder or under the subcontracts as reasonably requested by EOHHS;

2) Any information in its or their possession sufficient to permit EOHHS to comply with 42 CFR 438;

3) Any data from their clinical systems, authorization systems, claims systems, medical record reviews, Network Management visits, and Covered Individual and family input;

4) Delivery of time sensitive data to EOHHS in accordance with EOHHS timelines; and

5) High quality, accurate data in the format and in the manner of delivery specified by EOHHS;

b. The Contractor shall participate in work groups led by EOHHS to develop and comply with reporting specifications and to adopt the reporting models formulated by these work groups and approved by EOHHS, pursuant to the timeline established by EOHHS; and

c. Upon request, the Contractor shall 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.

2. Contract-Related Reports

Such reports shall include, but shall not be limited to, reports related to Contract performance, management and strategy.

a. The Contractor shall submit **Appendix E** reports in accordance with the timeframes and other requirements specified in **Appendix E**. For any report that indicates the Contractor is not meeting the targets set by EOHHS, the Contractor shall provide immediate notice explaining the corrective actions it is taking to improve performance. Such notice shall include root cause analysis of the problem the data indicates, the steps the Contractor has taken to improve performance, and the results of the steps taken to date. The Contractor may also include an executive summary to highlight key areas of high performance and improvement.

b. Failure to meet the reporting requirements in **Appendix E** shall be considered a breach of Contract.

3. Internal Management Reports

The Contractor shall submit to EOHHS, upon request, 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.

4. Additional Reports

a. In addition to the reports specifically required in **Appendix E**, the Contractor shall participate with EOHHS in the annual development of additional reports based on specific topics identified jointly by EOHHS and the Contractor as a result of ongoing analysis and review of data, and/or administrative and clinical processes. The Contractor shall participate in meetings led by EOHHS to develop analytical approaches and specifications for such reports. The Contractor shall produce data and written analyses of each topic in a time frame established by EOHHS but, at minimum, by the end of each Contract Year.

b. Pursuant to 42 CFR 438.3(g), the Contractor shall comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by EOHHS.

c. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with program report requirements set forth in 42 CFR 438.66(e).

5. Other Ad Hoc Reports

The Contractor shall provide EOHHS with additional ad hoc or periodic reports related to this Contract at EOHHS's request and as mutually agreed by the parties.

M. Certification Requirements

In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive Officer or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit to EOHHS the form provided in **Appendix E-2**, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of their knowledge, information and belief, after reasonable inquiry, under the penalty of perjury:

1. Data on which payments to the Contractor are based;

2. All enrollment information, Encounter Data, and measurement data;

3. Data related to medical loss ratio requirements in aggregate for the Contractor's Covered Individual population;

4. Data or information related to protection against the risk of insolvency;

5. Documentation related to requirements around Availability and Accessibility of services, including adequacy of the Contractor's Provider Network;

6. Information on ownership and control, such as that pursuant to **Section 5.1.O**;

7. Reports related to overpayments; and

8. Data and other information required by EOHHS, including but not limited to, reports and data described in this Contract.

Section 2.15 Financial Stability Requirements

Throughout the term of the Contract, the Contractor, at a minimum, shall meet the solvency standards established by EOHHS consistent with 42 CFR 438.116(b).

A. Financial Stability

Throughout the term of this Contract, the Contractor shall remain financially stable and maintain adequate protection against insolvency, as determined by EOHHS. To meet this general requirement, the Contractor, at a minimum, shall comply with, and demonstrate such compliance to the satisfaction of EOHHS, the solvency standards in this Contract. The Contractor shall also submit reports to EOHHS set forth in **Appendix E-4** of this Contract.

1. Cash Flow: The Contractor shall maintain sufficient cash flow and liquidity to meet obligations as they become due. The Contractor shall submit to EOHHS upon request a cash flow statement to demonstrate compliance with this requirement and a statement of its projected cash flow for a period specified by EOHHS.

2. Net Worth: As directed by EOHHS, the Contractor shall comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G § 25 (a) and 211 CMR 43:07(1) and continue to maintain an adjusted net worth in accordance with M.G.L. c 176G § 25(b) and 211 CMR 43:07(2).

3. Cash Reserves: Throughout the term of this Contract, the Contractor shall maintain a minimum cash reserve of $1,000,000 to be held in a restricted reserve entitled "Reserve for MassHealth Behavioral Health Managed Care Program Obligations." Funds from this restricted cash reserve may be dispersed only with prior written approval from EOHHS during the term of this Contract.

4. Working Capital Requirements: The Contractor shall 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 term of this Contract, the Contractor shall maintain a positive working capital balance, subject to the following conditions:

a. If, at any time, the Contractor's working capital decreases to less than 75% of the amount reported on the prior year's audited financial statements, the Contractor shall notify EOHHS within two business days and submit, for approval by EOHHS, a written plan to reestablish a positive working capital balance at least equal to the amount reported on the prior year's audited financial statements.

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

1) Does not maintain a positive working-capital balance; or

2) Violates a corrective plan approved by EOHHS.

5. Throughout the term of this Contract, the Contractor shall: a) remain financially stable, and b) maintain adequate protection against insolvency in an amount determined by EOHHS to be at least adequate to both:

a. Provide to Covered Individuals all BH Covered Services required by this Contract for a period of 45 days following the date of insolvency; and

b. Continue to provide all such services to Covered Individuals who are receiving Inpatient Services at the date of insolvency until the date of their discharge.

The Contractor shall maintain liability protection sufficient to protect itself against any losses arising from any claims against it, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance (see also **Section 5.3.R**).

B. Performance Guarantees and Additional Security

1. Insolvency Reserve

The Insolvency Reserve shall be defined as the funding resources necessary to meet the costs of providing services to Covered Individuals for a period of 60 days in the event that the Contractor is determined insolvent. For the first year of the Contract, the Contractor shall provide at minimum fifty-percent of the Insolvency Reserve, consistent with the risk corridor calculation.

a. 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.

b. The Insolvency Reserve calculation shall be an amount equal to 60 days of the Contractor's Capitation Payment revenue.

c. Within 30 calendar days of receipt of the Insolvency Reserve calculation, the Contractor shall submit to EOHHS written documentation of its ability to satisfy the Insolvency Reserve requirement. The documentation shall be signed and certified by the Contractor's chief financial officer.

d. The Contractor shall submit to EOHHS for approval, documentation that the Contractor has satisfied the insolvency Reserve Requirement through any of the following, or combination of the following:

1) Restricted cash reserves;

2) Net worth of the Contractor;

3) Performance bond or guarantee;

4) Insolvency insurance;

5) An irrevocable letter of credit; or

6) A written guarantee from the Contractor's parent or organization.

2. Prior to the Operational Start Date, the Contractor shall provide EOHHS with:

a. Performance Guarantees as specified in **Appendix H-2**, the form of which shall be subject to EOHHS's prior review and approval.

b. A promissory note from the Contractor's parent(s) to guarantee performance of the Contractor's obligation to provide Covered Services in the event of the Contractor's insolvency, the form and amount of which shall be subject to EOHHS's prior review and approval.

c. A promissory note from the Contractor's parent(s) 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 insolvency, the form and amount of which shall be subject to EOHHS's prior review and approval.

C. Medical Loss Ratio (MLR) Requirements

1. Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio (MLR) in accordance with 42 CFR 438.8. The Contractor shall perform such MLR calculation in the aggregate for the Contractor's Covered Individual population and individually for each Rating Category. Within 212 days following the end of the Contract Year, the Contractor shall report such MLR calculations to EOHHS in a form and format specified by EOHHS and as set forth in **Appendix E-4**. Such report shall include at least the following, pursuant to 42 CFR 438.8(k):

a. Total incurred claims

b. Expenditures on quality improving activities;

c. Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5),(7),(8), and (b);

d. Non-claims costs;

e. Premium revenue;

f. Taxes, licensing, and regulatory fees;

g. Methodology(ies) for allocation of expenses;

h. Any credibility adjustment applied;

i. Any remittance owed to the State, if applicable;

j. The calculated MLR;

k. A comparison of the information reported in this Section with the audited financial report required under this **Section 2.15**;

l. A description of the aggregation method used in calculating MLR;

m. The number of Covered Individual months;

n. An attestation that the calculation of the MLR is accurate and in accordance with 42 CFR 438.8; and

o. Any other information required by EOHHS.

2. As further specified by EOHHS, the Contractor shall calculate its MLR in accordance with 42 CFR 438.8, as follows:

a. The numerator of the Contractor's MLR for each year is the sum of the Contractor's incurred claims; expenses for activities that improve health care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

b. The denominator of the Contractor's MLR for each year is the adjusted premium revenue as set forth in 42 CFR 438.8(f). For purposes of this Section, the Contractor's adjusted premium revenue shall be the Contractor's premium revenue as defined in 42 CFR 438.8(f)(2) minus the Contractor's federal, state, and local taxes and licensing and regulatory fees as defined in 42 CFR 438.8(f)(3).

3. As further directed by EOHHS, the Contractor shall maintain a minimum MLR of 85 percent in the aggregate for the Contractor's Covered Individual population. If

the Contractor does not maintain such minimum, the Contractor shall, pursuant to 42 CFR 438.8(j), remit an amount equal to the difference between actual medical expenditures and the amount of medical expenditures that would have resulted in a MLR of 85%.

D. Auditing and Other Financial Requirements

The Contractor shall:

1. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits must comply with the following requirements and must be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards:

    a. No later than 120 days after the Contractor's fiscal year end, the Contractor shall submit to EOHHS its most recent year-end audited financial statements (balance sheet, statement of revenues and expenses, source and use of funds statement and statement of cash flows that include appropriate footnotes) both:

        1) Specific to this Contract; and

        2) If directed by EOHHS, statements for the overall organization or consolidated statements that include other lines of business or other Medicaid products.

    b. The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS an attestation report from its independent auditor on the effectiveness of the internal controls over operations of the Contractor related to this Contract in accordance with statements and standards for attestation engagements as promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report; provided, however, if the Contractor is Service Organization Control (SOC) compliant, the Contractor shall annually submit a copy of the SOC report in lieu of the attestation report described above within 30 days of the Contractor's independent auditors issuing its SOC report.

    c. The Contractor shall submit, on an annual basis after each annual audit, the final audit report together with all supporting documentation, a representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

2. Submit annually, by September 30th, a Financial Ratio Analysis that describes the Contractor's performance for financial ratios required by EOHHS in accordance with **Appendix E-4**. The report shall be generated from the Contractor's audited financial statements.

3. Maintain separate records of all Direct and Indirect administrative Costs, in accordance with generally accepted accounting principles, and make these financial records available to EOHHS on a quarterly basis, for audit purposes.

4. Obtain EOHHS's approval of and utilize a methodology to estimate IBNR claims adjustments.

5. Immediately notify 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.

6. Notify 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.

7. Advise EOHHS no later than 30 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.

8. Not invest funds in, or loan funds to, any organization in which a director or principal officer of the Contractor has a financial interest.

9. Provide 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. Such information shall include, but not be limited to, the quarterly revenue expenses and utilization reports set forth in **Appendix E-4**; the annual financial ratios set forth in **Appendix E-4**; and the annual outstanding litigation report set forth in **Appendix E-4**.

E. Non-Payment and Reporting of Provider Preventable Conditions

1. 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 Section 2702 of the Patient Protection and Affordable Care Act and regulations promulgated thereunder;

2. In accordance with 42 CFR 438.3(g), the Contractor shall:

   a. As a condition of payment, comply with the requirements mandating Provider identification of Provider Preventable Conditions, as well as the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR 434.6(a)(12) and 447.26;

   b. Report all identified Provider Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Appendix E-1**.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 CFR 434.6(a)(12), 42 CFR 438.3(g), and 42 CFR 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 CFR 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; and

         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;

F. Non-Payment and Reporting of Preventable Hospital Readmissions

As directed by EOHHS, 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.

G. Reporting

The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 2.15** or in **Appendix E-4**, in accordance with specified timetables, definitions, formats and assumptions, and certifications, as well as any ad hoc financial reports required by EOHHS.

Section 2.16 Operational Audits

A. The Contractor or its Material Subcontractor shall cooperate and facilitate EOHHS's conduct of periodic on-site visits as described under **Section 3.1.C.4** of this Contract. At the time of such visits, the Contractor or Material Subcontractor shall assist EOHHS or its designee in activities pertaining to an assessment of all facets of the Plan's operations, including, but not limited to financial, administrative, clinical, pharmacy and claims processing functions and the verification of the accuracy of all data submissions to EOHHS as described herein.

B. The Contractor or Material Subcontractor shall respond to requests for information associated with such on-site visits in a timely manner, and shall make senior managers available for on-site reviews.

Section 2.17 Additional Enrollee Groups

Consistent with **Section 3.6**, EOHHS may require the Contractor to accept additional MassHealth Enrollee Groups. The Contractor shall cooperate with EOHHS to develop an implementation strategy for providing services to any new Covered Individual group.

Section 2.18 Third-Party Liability Benefit Coordination and Recovery

A. General Requirements

1. The Contractor shall develop and submit to EOHHS for approval a work plan for Third-Party Liability (TPL) benefit coordination and recovery that:

    a. Ensures that MassHealth is the payer of last resort for the BH Covered Services provided under this Contract;

    b. Ensures recovery of funds inappropriately paid to Network Providers;

    c. Avoids payment for all Claims or services that are subject to third-party payment;

d. Ensures that the Contractor identifies and determines the legal liability of third parties to pay for services furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only;

e. Includes tasks and time frames associated with the plan; and

f. Addresses systems and resources required to perform at a minimum the following activities:

1) Identification of Covered Individuals and Uninsured Individuals who have other health insurance, and notification of EOHHS with respect to Covered Individuals; and

2) Reporting to EOHHS information on cost avoidance and recovery amounts.

B. Payment Recovery

The Contractor shall retain any payments recouped from Network Providers as a result of the discovery of TPL, deposit them into the Direct Service Reserve Account (DSRA) and use all such recoveries to offset BHP expenditures related to the delivery of BH Covered Services.

C. System Requirements Related to Third-Party Liability and Benefit Coordination

Unless otherwise directed by EOHHS, the Contractor shall coordinate the Behavioral Health benefits of Covered Individuals with TPL with the other insurance resource, such as Medicare or commercial insurance, as described in **Section 2.18.A**. In order to meet this requirement, the Contractor shall have all necessary changes to its operations in place by the Operational Start Date, and shall continue to make all appropriate changes to its operations in compliance with any new policies from the EOHHS TPL Unit, including but not limited to changes to the following:

1. Management information systems;

2. Claims authorization systems;

3. Claims payment systems;

4. Staffing within the Claims Operation Department; and

5. Reporting.

D. Claims Payment Requirements for Covered Individuals under Age 21 with TPL

1. The Contractor shall ensure that providers who provide BH Covered Services to Covered Individuals with TPL make diligent efforts to identify and obtain payment from all other liable parties, including insurers, as described in 130 CMR 450.316;

2. If a third-party resource is identified after the Provider has already billed and received payment from the Contractor, the Provider promptly returns any payment it received from the Contractor and ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

3. The Contractor shall ensure that providers who submit Claims for Covered Individuals who have Medicare in addition to Medicaid:

    a. bill the Medicare fiscal intermediary or carrier in accordance with their billing rules, including using the appropriate Medicare claim form and format;

    b. accept assignment according to Medicare instructions; and

    c. follow the Contractor's billing instructions, including any billing instructions specific to Medicare crossover claims.

4. The Contractor shall not pay Providers:

    a. who do not make diligent efforts to obtain payment from other liable parties; or

    b. for services provided to a Covered Individual, if on the date of service the Covered Individual had other health insurance, including Medicare, that may have covered the service, and the Provider did not participate in or resort to the Covered Individual's other insurance plan, including Medicare.

5. For Covered Individuals under 21 with commercial Third Party Liability, payment shall not exceed the Covered Individual's liability, including co-insurance, deductibles and copayments; or the Provider's charges or the Contractor's payment amount, whichever is less.

6. For Covered Individuals under 21 with Medicare, the payment amount shall not exceed the coinsurance and deductible amounts as reported on the explanation of benefits or remittance advice from Medica re; the Contractor's payment amount, or the Medicare-approved amount, except for specific programs as approved and directed by EOHHS.

7. The terms of this **Section 2.18.D** apply to all Covered Services provided to Covered Individuals.

Section 2.19 PCC Plan Management Support Services (PMSS) Program

A. PCC Plan Management Support Services (PMSS)

The Contractor shall:

1. Establish, implement and maintain a PMSS program for PCCs that measures, monitors and promotes improvements in health care delivery systems, including integration of care, at the PCC practice level;

2. Review, update, and establish any new written standard operating policies and procedures for the Contractor's staff associated with the PMSS program;

3. Provide to EOHHS for review and approval, copies of the standard operating policies and procedures for the PMSS program as part of the readiness review process and annually, within three months of the first day of the Contract Year and modify such policies and procedures in support of the PCC Plan as directed by EOHHS;

4. Conduct profiling of PCC Plan providers as detailed in **Section 2.8.H**.

5. Accept and promptly utilize any data files that EOHHS provides in connection with the PMSS program, in the format determined by EOHHS;

6. Notify EOHHS if, after diligent effort on the part of the Contractor, a PCC refuses to cooperate with the PMSS program or other Contract requirements;

7. Develop and implement written action plans, as needed, related to reports produced for PCC Service Locations. Prior to developing such reports, the Contractor shall certify the accuracy of the data to EOHHS regarding these reports as required in **Section 2.14.M;**

8. Provide support to PCCs consistent with integration of Behavioral Health, medical care, long-term services and support, and social services;

9. Provide support to PCCs as required related to ICMP activities as follows:

    a. Strengthen PCCs' relationship to ICMP, including improving communications, and enhancing and expanding use of ICMP for Enrollees; and

    b. Manage and coordinate PCC inquiries, requests, and concerns regarding interacting with ICMP.

10. Provide support to PCCs as required related to PBCM activities as follows:

    a. Support PCCs with the implementation of new PBCM programs, including evaluating the PCC for readiness to perform care management activities;

    b. Provide on-going support to the PBCM program, including identifying strategies for process improvements for outreaching and engaging Enrollees in the PBCM program, improving workflows, and providing technical assistance related to reporting and other operational issues;

c. Monitor compliance of PBCM programs with care management activities; and

d. Manage and coordinate PCC inquiries, requests, and concerns regarding interacting with the PBCM program.

11. Support PCCs in understanding and, as appropriate, transitioning to the ACO programs, as directed by EOHHS. These areas of support may include but are not limited to:

a. Maintaining and implementing protocols for handling PCC inquiries, requests and concerns received by the Contractor regarding the ACOs; and

b. Collaboratively working with current PCC sites, which may be joining an ACO in the future, to assist with coordination and transition of care.

12. Represent the PCC Plan and EOHHS with respect to PCC Plan activities at provider conferences, community agency meetings and other forums that require a PCC Plan presence, if requested or approved by EOHHS;

13. Establish relationships with other EOHHS contractors (e.g., the MassHealth Contact Center vendor, the Business Support Services vendor) and refer PCCs to the appropriate vendor in order to resolve questions and issues such as eligibility, claims and billing inquiries, and to provide file updates; and

14. In addition to submission of the monthly PMSS report(s) outlined in **Appendix E-1**, submit to EOHHS an annual report on the PMSS activities for the Contract Year.

B. Compliance with PCC Plan Provider Contract with EOHHS

The Contractor shall:

1. Annually submit a report to EOHHS documenting the process used to monitor PCC compliance with the EOHHS PCC Plan Provider Contract in areas such as outreach and appointment times as set forth in **Appendix C**;

2. Refer PCCs to the Customer Service Center for Providers for enrollment with the MassHealth Provider Online Service Center (POSC) and Job Aids (Enrollment Roster, Referral) to support compliance with the PCC Contract;

3. Reinforce the importance of updating and inform PCCs on how to update PCC information with MassHealth Customer Service Center for Providers including but not limited to Provider information and capacity;

4. Assist PCC Plan staff with ensuring that all Providers who wish to remain in the PCC Plan network sign and return to EOHHS new PCC Provider Contracts whenever MassHealth updates such contracts; and

5. Report to EOHHS any PCC who could benefit from outreach by MassHealth's Customer Service Center for Providers, Provider Outreach and Education Unit to support delivery of services to PCC Plan members.

C. PMSS Site Visits

1. PMSS Introduction Visit to new or returning PCCs

The Contractor shall:

a. Conduct an introduction visit with each PCC new to participation in or returning to the PCC Plan, regardless of the PCC's enrollment roster/panel size;

b. Ensure that the PMSS introduction visit includes:

1) An introduction to the Contractor and a description of the Contractor's role and the PMSS program;

2) A discussion regarding the PCC's current priorities and engagement with MassHealth Covered Individuals and health plans;

3) A discussion of the current EOHHS and PCC Plan goals and policies;

4) A description of available Contractor programs, including but not limited to care management (ICMP and PBCM) and CBHCs;

5) A description of materials that are used in the PMSS program;

6) The PCC's Support Manager's name, telephone number, and e-mail address; and

7) A description of any additional reports and and/or information as directed by EOHHS.

2. PMSS On-going Site Visits

After the introduction visit, the Contractor shall conduct PMSS site visits according to an EOHHS-approved schedule. The Contractor shall review the needs of the PCC or PCC Service Location prior to scheduling a site visit, including PCC-specific and/or PCC Service Location-specific data, and shall conduct site visits to PCCs and PCC Service Locations as appropriate, or as requested by the PCC or PCC Service Location.

a. Within 30 days of the start of the Contract Year, the Contractor shall develop and propose for EOHHS's approval a detailed plan for PMSS site visits to all PCCs and PCC Service Locations that meet the site visit

criteria agreed to by EOHHS. Such proposal shall include, at a minimum, the following elements:

1) A schedule for PMSS site visits that is specific to each PCC and PCC Service Location, based on the agreed-upon site visit criteria and the PCC's priorities and performance;

2) The criteria by which PCCs and PCC Service Locations will be visited, including frequency for visits;

3) The content and subject matter of the site visits or, for those PCCs that may not receive a visit, other communications;

4) A description of how the Contractor will support PCC questions regarding Claims payment or other PCC Plan services not managed by the Contractor;

5) A description of how the Contractor will prioritize and promote integration of Behavioral Health and medical care, and care management efforts for Enrollees as part of each site visit;

6) A method for documenting the site visits and the communications that have taken place with PCCs and PCC Service Locations;

7) A method and timeframe for evaluating the success of PMSS site visits under the Contractor's proposal; and

8) A description of any additional reports and/or information as directed by EOHHS.

b. Subject to EOHHS approval, the Contractor shall implement its PMSS site visit proposal.

c. The Contractor shall work with PCCs and PCC Service Locations to schedule a convenient time for PMSS site visits.

d. The Contractor shall make best efforts to involve the medical director of the PCC in the site visit, and shall advise the PCCs and PCC Service Locations that appropriate clinical and non-clinical staff should attend the site visit.

e. The Support Manager shall discuss other related PCC issues as identified by the PCC or the Support Manager, or as directed by EOHHS.

f. The Support Manager shall conduct the PMSS site visit and other EOHHS or Contractor staff shall attend, at the discretion of EOHHS.

g. At each PMSS site visit, the Support Manager shall review with the PCC any new PCC Plan Management Support Services Materials and inquire of

any PCC- developed materials useful for Enrollees including how and where the materials can be accessed.

h. The Contractor shall maintain and document ongoing communication with PCCs and PCC Service Locations through additional site visits, email, and telephone follow-up, as appropriate or as directed by EOHHS.

i. The Contractor and EOHHS may negotiate a modified schedule and methodology for PMSS site visits and, with EOHHS approval, the Contractor shall perform PMSS site visits in accordance with such alternate schedule and methodology.

j. The Contractor shall prepare, deliver to, and discuss with PCC Plan staff a detailed report of site visits on a monthly basis. The Contractor and EOHHS may negotiate report format, contents, and frequency during the term of the Contract.

3. PMSS Joint Visits with the Contractor's Behavioral Health Provider Quality Manager and a Member of the Contractor's ICMP

The Contractor shall develop and propose for EOHHS's approval a plan for PMSS and BH or ICMP joint site visits. Such proposal shall include, at a minimum:

a. The criteria by which joint visits will be conducted;

b. The content and subject matter of the site visit; and

c. A description of how the Contractor will support integration of Behavioral Health, medical care, and social services.

D. PCC Performance Dashboard

1. PCC Performance Dashboard (PD)

At the request of EOHHS, the Contractor shall:

a. Develop a PCC Performance Dashboard (PD) for each PCC and PCC Service Location(s) that meets the threshold number of Enrollees as agreed to by EOHHS and the Contractor. The PD shall be implemented and updated according to a schedule determined by EOHHS;

b. Produce the PDs as requested by EOHHS;

c. Ensure the PDs are formatted in a user-friendly style approved by EOHHS;

d. One month prior to the dissemination of the PD, prepare for EOHHS's prior approval a written user's guide that explains the purpose of the report and the information it contains;

e. Include in each PD PCC-specific site information and PCC Panel Enrollee demographics;

f. Include in each PD all measures provided by EOHHS. Measures shall be reported by both PCC and PCC Service Location level, when applicable. Such measures are subject to change during the term of the Contract. For each measure, the Contractor shall:

1) Present PCC-specific data; and

2) Compare each PCC's performance using appropriate benchmarks and trended indicator rates as directed by EOHHS, such as:

a) aggregate PCC Plan performance;

b) available national, state, local or industry benchmarks; and

c) the PCC's PD trended data;

g. Include in the PD a one-page summary of trended rates for the PCC and by PCC Service Location for all clinical measures, as appropriate; compare the Service Location rates to that of the PCC entity, other PCC Service Locations, the overall PCC Plan rates, and other benchmarks as directed by EOHHS;

h. Maintain a password accessible website that provides each PCC and PCC Service Location access to their current PD report and ensure that the current PD report remains posted until the next cycle's PD is released or, subject to EOHHS's approval, develop an alternative mechanism for dissemination of the PCC PD report;

i. Within one business day of posting the updated PD, notify PCCs and PCC Service Locations via email that the reports are available; and

j. Design and propose for EOHHS approval additional clinical indicators that address medical and Behavioral Health integration as aligned with EOHHS's dashboard.

2. Additional Reports and Reporting Activities

a. The Contractor shall propose to EOHHS additional reports to support the PMSS program, as appropriate.

b. Upon the request of EOHHS, the Contractor shall produce additional PMSS reports, including but not limited to, analysis of trends identified from PMSS data, data and analytics on population health management, and other supplemental and management reports that support quality and integration activities as negotiated by the parties.

c. Upon the request of EOHHS, the Contractor shall participate in activities to enhance and align with any existing dashboards designed by EOHHS. EOHHS and the Contractor may negotiate alternate PD measures, report formats, methods and timeframe for these activities including design and propose for EOHHS approval additional clinical indicators that address medical and Behavioral Health integration.

d. EOHHS may, at its discretion, instruct the Contractor to replace the production of certain existing reports with reports generated for PCCs and PCC Service Locations as part of other EOHHS programs and/or initiatives.

3. Reports for PCCs

The Contractor shall:

a. Develop and distribute reports to the PCCs at a frequency approved by EOHHS in content areas, including but not limited to, Enrollees identified as High Risk as defined by EOHHS and:

1) Their enrollment in the Care Management Program;

2) Their emergency department utilization; and

3) The Top Five Outpatient Behavioral Health Report that identifies the top five Behavioral Health providers of outpatient services used by PCC Plan Enrollees in a PCC panel;

b. Maintain a secure transmittal process for such reports to each PCC and PCC Service Location.

E. PCC Plan Management Support Materials

The Contractor shall:

1. Develop and update the Health Literacy Library as directed by EOHHS. Topics shall clearly and concisely describe relevant health education, including medical, Behavioral Health, substance use, chronic disease management, and wellness/prevention topic areas. The Contractor shall submit new or updated materials to EOHHS for prior approval.

2. Establish a plan to review with EOHHS the current PCC Plan Management Support Materials, at EOHHS's request, to determine the need for revised, additional, or replacement Support Material necessary to support improved Member experience and integration of physical and Behavioral Health care. The Contractor shall deliver materials for EOHHS approval within required timeframes, as determined by EOHHS.

3. Maintain a sample original package of all PCC Plan Management Support Materials and an inventory including a list of topics for which PCC Plan Management Support Materials are available.

F. Education and Training

The Contractor will be responsible for the coordination of educational and training opportunities for PCCs and PBCMs that serve Enrollees. The Contractor shall collaborate with stakeholders and subject matter experts both internally and externally to identify relevant training topics that will support current and future EOHHS initiatives. These shall include educational opportunities, such as learning collaboratives, regional learning sessions, or other educational modes that support PCCs and PBCMs that serve Enrollees to engage in group learning and identified topics.

Section 2.20 Health Equity

The Contractor shall participate in, and support EOHHS regarding efforts to reduce health disparities, address social risk factors, and achieve Health Equity for Covered Individuals. The Contractor shall also engage Covered Individuals, staff and Providers in its own Health Equity initiatives to comply with this Section and the Contract.

A. Health Equity Committee

The Contractor shall establish and maintain a Health Equity Committee (HEC) which shall be chaired by the Health Equity Director and be designated by, and accountable to, its governing board for the duration of the Contract. The composition of the HEC shall, to the extent possible, include individuals that can represent the diversity of the MassHealth population. Responsibilities of the HEC include but are not limited to:

1. Developing and steering implementation of the Health Equity strategy of the Contractor's organization;

2. Monitoring progress towards addressing inequities;

3. Developing the annual Health Equity report; and

4. Sharing all relevant information with the Contractor's Advisory Committees.

B. Population and Community Needs Assessment

1. The Contractor shall conduct a population and community needs assessment that provides an initial description of the Contractor's Covered Individual population, including:

   a. A brief description of the population of Covered Individuals the Contractor serves and the communities in which they live;

   b. A description of the characteristics of such population and communities, including, at a minimum, demographic characteristics such as age, race,

ethnicity, languages spoken, disability status, sexual orientation, gender identity, and other salient characteristics of the population that inform the Contractor's strategy for improving the quality and reducing the cost of Covered Individual care; and

c. A description of the health, functional, and other care needs of such population and communities, including but not limited to a description of the population's Behavioral Health needs;

2. The Contractor shall annually update and collect additional data on its population and community as part of the Contractor's population and community needs assessment.

C. Health Equity Strategic Plan and Report

The Contractor shall create, monitor, and update as needed a five-year Health Equity strategic plan, which shall be submitted to EOHHS for review and approval. In developing the Contractor's Health Equity strategic plan, the Contractor shall seek input from the Contractor's HEC, providers, Covered Individuals, and their families.

1. The Health Equity Strategic Plan shall describe:

a. The Contractor's approach to establishing a culture of equity that recognizes and prioritizes the elimination of inequities through respect, fairness, cultural competency, and advocacy, including through the provision of trainings for Health Equity, implicit bias, anti-racism, and related trainings to all staff who interact with Covered Individuals;

b. The Contractor's approach to ensure all Contractor policies and procedures are designed to promote Health Equity;

c. How the Contractor used its population and community needs assessment to inform the Health Equity Strategic plan;

d. The Contractor's planned approach to maintaining robust structures to identify and understand inequities to support the implementation of evidence-based interventions. This includes reporting on key performance indicators, including but not limited to, quality metrics on which the Contractor will be evaluated by EOHHS as part of this Contract, stratified by social risk factors, which may include but are not limited to race, ethnicity, language, disability, sexual orientation, and gender identity;

e. The Contractor's planned interventions to reducing inequities; and

f. The Contractor's targeted Health Equity-related milestones for each year of the Contract and specific Health Equity key performance indicators the Contractor will use to monitor progress towards goals including annual

improvement target(s) that are specific, measurable, actionable, and relevant.

2. On an annual basis, the Contractor shall submit to EOHHS a Health Equity report that shall summarize its Health Equity work to date under this Contract including progress towards targeted milestones and any other achievements in the preceding year and since the beginning of the Contract.

3. The Contractor shall meet with EOHHS to discuss the Health Equity Report, as requested by EOHHS.

4. The Contractor shall publicly post the executive summaries of its Health Equity Strategic Plan and its annual Health Equity reports on its website, and make these documents available to EOHHS for posting on EOHHS' website.

D. Health Equity, Anti-Racism, Implicit Bias, and Related Trainings

The Contractor shall ensure that meaningful and appropriate trainings to advance Health Equity are periodically received by all staff and Network Providers that interact with Covered Individuals.

1. The health equity training content shall include, at a minimum, the following:

   a. An overview of the Contractor's Health Equity Strategy, including populations prioritized for intervention;

   b. The role(s) trainees can play to promote and achieve Health Equity;

   c. A description of how the training content reinforces the Contractor's mission, values, and priorities and how trainees have applied or are expected to apply the training to their work;

   d. The importance of and best practices related to collecting self-reported social risk factor data such as race, ethnicity, language, disability (RELD), sexual orientation and gender identity (SOGI) and addressing inequities experienced by Covered Individuals with social risk factors;

   e. Adherence to CLAS standards;

   f. The role of trauma-informed practices for marginalized individuals;

   g. Identifying and mitigating the impact of implicit biases on delivery of high quality, equitable health care;

   h. Anti-racism including the role of structural and institutional racism in health care;

   i. How to communicate effectively about issues related to racial equity; and

   j. Appreciating the need to practice cultural humility in one's life and work.

2. The Contractor shall implement additional or specific Health Equity training topics, as directed by EOHHS.

3. The Contractor shall document staff participation in required training and address staff non-compliance with training policies.

4. As directed by EOHHS, the Contractor shall evaluate the effectiveness of its training programs on an annual basis.

E. Culturally and Linguistically Appropriate Services (CLAS) Standards

The Contractor shall:

1. Ensure its Provider Network provides CLAS to Covered Individuals, including being responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under the Contract;

2. Ensure that all Network Providers understand and comply with their obligations under state or federal law to assist Covered Individuals with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations;

3. Ensure that multilingual Network Providers and interpreters/transliterators are available for those who are Deaf or hearing-impaired, to the extent that such capacity exists within the service area;

4. Ensure that it identifies and acts on opportunities to improve the availability of fluent staff or skilled translation services in Covered Individuals' preferred languages and opportunities to improve the cultural appropriateness of Covered Individuals' care;

5. Have clear and user-friendly processes and policies in place for Covered Individuals to request linguistic interpreters and other linguistic and/or physical accommodations which shall, at a minimum, be posted on the Contractor's website and included in Covered Individual Handbooks;

6. Adopt and implement national CLAS standards, complete a CLAS Standards Self-Evaluation annually to assess performance and continuous improvement, and take immediate action to improve the delivery of CLAS when deficiencies are noted;

7. Annually submit its completed CLAS Standards Self-Evaluation to EOHHS along with a descriptive summary of how the Contractor has made and will make improvements; and

8. Assess and address the CLAS needs of the population and communities it serves and include CLAS information in its annual Health Equity Report as required in **Section 2.20** including:

a. The linguistic accessibility needs of Covered Individuals, including preferred languages, the needs of Covered Individuals who are Deaf or hard of hearing, and needs related to health literacy;

b. The process utilized to verify that the Contractor's Provider Directory accurately capture member accommodations capabilities; and

c. Demonstrating adoption of national CLAS standards within the organization and proposing how it shall further develop CLAS and evaluate gaps in achieving CLAS.

Section 2.21 COVID-19 Efforts

A. As further specified by EOHHS, the Contractor shall help manage COVID-19 and any additional Public Health Emergencies (PHE) as set forth in MassHealth bulletins, including but not limited to MassHealth managed care entity bulletins, and other MassHealth guidance. Such activities to help manage COVID-19 or other PHE shall include, but may not be limited to:

1. Taking all necessary steps to enable Covered Individuals to obtain medically necessary and appropriate Covered Services.

2. Delivering all Covered Services in an amount, duration and scope that is no more restrictive than the MassHealth fee-for-service program, and staying up to date on any changes to the amount, duration, and scope of services that MassHealth may announce via bulletins or guidance.

3. Communicating, with EOHHS prior approval, relevant benefits, prevention, screening, testing, and treatment options to Covered Individuals and guidelines for contacting a Covered Individual's local board of health or health care provider.

Section 3. EOHHS RESPONSIBILITIES

Section 3.1 Contract Management

A. Administration

EOHHS shall:

1. Designate a Contract Manager for the Contract, who shall act as liaison, coordinate all requests and activities between the Contractor and EOHHS, and between the Contractor and the other state agencies involved with or affected by the Contract, for the duration of the Contract. EOHHS may change its designation of Contract Manager at any time during the Contract, and shall provide the Contractor with notification of any such change. The Contract Manager shall represent EOHHS in all programmatic and operational aspects of the Contract.
2. Provide the Contractor with available information and data in its possession necessary for successful performance of the Contract.
3. Furnish the Contractor with copies of EOHHS regulations, policies and procedures that may materially affect the Contractor's performance of its contractual obligations.
4. Notify the Contractor of any changes to the PCC Plan, the PCACOs and other EOHHS programs, regulations, policies and procedures, operations or systems that may materially affect the Contractor's performance of its contractual obligations.
5. Notify the Contractor of the Contract requirements on which EOHHS will base its annual review of the Contractor's performance on its Quality Management/Quality Improvement program.
6. Review and approve all materials, policies and procedures developed by the Contractor when such review and approval is required by the Contract.
7. Review the Contractor's submitted reports and reserve the right to request additional reports.
8. Meet with the Contractor's representative(s) on a monthly basis, or more often as either party deems necessary.
9. At its discretion, attend meetings or other activities conducted by the Contractor.
10. At any time during the term of the Contract, as appropriate, initiate negotiations with the Contractor to revise the scope of the Contract to meet EOHHS's needs.
11. Review any Contractor-proposed revisions to the scope of the Contract and approve, reject or modify the Contractor's proposal.

12. Pay the Contractor in accordance with **Section 4** of the Contract.

13. At its discretion, attend Provider site visits conducted by the Contractor.

14. Inform the Contractor of new PCCs to be included in PMSS activities.

15. EOHHS may, in its discretion direct the Contractor to establish payment rates that are no greater than a certain percentage of the MassHealth Fee-For-Service (FFS) rate or another payment rate specified by EOHHS. Such maximum payment rate shall not be less than 100% of the MassHealth FFS rate. EOHHS may approve an exemption from any such requirement upon the Contractor's written request, which shall include the reason(s) why it is necessary for the Contractor to pay a higher rate, such as in order for the Contractor to implement value-based payment arrangements. Nothing in this Section shall relieve the Contractor of its obligations to ensure access to BH Covered Services in accordance with **Section 2.6** of this Contract.

16. At its reasonable discretion, impose financial penalties or other sanctions on the Contractor for failure to meet certain contract provisions or performance measures as detailed in **Sections 5.3.L and M**.

B. Contract Readiness Review

Prior to the Operational Start Date, EOHHS shall conduct a readiness review of the Contractor.

1. EOHHS shall conduct a readiness review of the Contactor that may include on-site review. This review shall include an assessment of the Contractor's ability and capability to perform satisfactorily in the areas set forth in 42 CFR 438.66(d)(4), as applicable. Additionally, this review may include, but is not limited to, the elements described in **Section 2.2.B.3.b**.This review begin no later than 90 days prior to the Operational Start Date.

2. EOHHS may conduct the readiness review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional readiness review in the event that additional populations become managed care eligible or eligible to enroll with the Contractor.

3. EOHHS shall identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its reasonable discretion, allow the Contractor to propose a plan to remedy all deficiencies prior to the Operational Start Date. Alternatively, EOHHS may, in its reasonable discretion, postpone the Operational Start Date if the Contractor fails to satisfy all readiness review requirements

4. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Operational Start

Date, and EOHHS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

C. Performance Evaluation

EOHHS shall, at its discretion:

1. Annually review the impact and effectiveness of the Quality Management/Quality Improvement program by reviewing the results of performance improvement projects, performance on standard measures, and all other quality initiatives specified in **Section 2.13.C.**

2. On an ongoing basis, monitor and evaluate the Contractor's compliance with the terms of this Contract, including, but not limited to, the reporting requirements in **Appendix E-1,** the performance measurement and performance improvement projects set forth in **Section 2.13.C** and the Behavioral Health performance incentives set forth in **Appendix G**, and shall at its discretion, monitor and evaluate any or all of the Contractor's operational processes and metrics that indicate the Contractor's organizational health. EOHHS will provide the Contractor with the written results of such evaluations, including, at its discretion, how the Contractor has performed relative to its own previous performance and relative to the MassHealth benchmarks.

3. Conduct periodic audits of the Contractor, as further described in **Sections 4.8 and 5.4**, including, but not limited to, annual Quality Improvement Projects, as specified in **Section 2.13.C**, and an annual operational review site visit pursuant to **Section 2.16**.

4. Perform additional periodic programmatic and financial reviews. These may include on-site inspections and audits, by EOHHS or its agent, of the records of the Contractor and Network Providers. EOHHS reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and onsite visits to Network Providers, the existence of a contract between the Contractor and each individual Provider in the Provider Network;

5. Evaluate, in conjunction with the U.S. Department of Health and Human Services, through inspection or other means, the quality, appropriateness, and timeliness of services performed by the Contractor and all Behavioral Health Network Providers and PCC Plan Providers.

6. On a semiannual basis, conduct a "lessons learned" exercise with the Contractor. The results shall be used by EOHHS and the Contractor to improve and refine performance as it relates to the responsibilities of this Contract.

7. Provide reasonable notice to the Contractor prior to any on-site visit to conduct an audit, and further notify the Contractor of any records EOHHS wishes to review.

8. Inform the Contractor of the results of any performance evaluations and of any dissatisfaction with the Contractor's performance, and reserve the right to demand a corrective action plan as set forth in **Section 5.3.M**, or to apply one or more of the sanctions provided in **Section 5.3.L**, including termination of the Contract in accordance with **Section 5.5**.

Section 3.2 Coordination of Benefits

A. EOHHS shall, via the HIPAA 834 Outbound Enrollment file, provide the Contractor with all third party health insurance information on Covered Individuals where it has verified that third party health insurance exists.

B. EOHHS shall refer to the Contractor the Covered Individual's name and pertinent information where EOHHS knows a Covered Individual has been in an accident or had a traumatic event where a liable third party may exist.

C. EOHHS shall develop Base Capitation Rates that are net of expected TPL recoveries, consistent with the Contractor's obligation under this Contract to recover claims paid to Providers where the other insurer was primary.

Section 3.3 Enrollment and Disenrollment

A. EOHHS shall, as appropriate, enroll, disenroll and re-enroll Covered Individuals with the Contractor. EOHHS shall:

1. Maintain the sole responsibility for the enrollment of Covered Individuals into the Contractor's plan, as described in this **Section 3.3**. The Contractor shall accept all Covered Individuals enrolled or re-enrolled by EOHHS.

2. On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Daily Enrollment file, information pertaining to all enrollments, including the Effective Date of Enrollment, which will be updated on a daily (business day) basis.

3. At its discretion, and as appropriate, instruct the Contractor to resolve enrollment discrepancies through a manual system approved by EOHHS.

4. At its discretion, automatically re-enroll on a prospective basis with the Contractor any Covered Individuals who were disenrolled due to loss of eligibility and whose eligibility was re-established by EOHHS.

5. EOHHS shall disenroll a Covered Individual from the Contractor's plan and he or she shall no longer be eligible for services following:

a. Loss of MassHealth eligibility;

b. Completion of the Covered Individual's voluntary disenrollment request; or

c. Loss of eligibility for MassHealth Managed Care.

6. Make best efforts to provide the Contractor with the most current demographic information available to EOHHS. Such demographics shall include, when available to EOHHS, the Covered Individual's name address, MassHealth identification number, date of birth, telephone number, race, gender, ethnicity and primary language.

7. Review and respond to written complaints from the Contractor about EOHHS's Customer Services vendor or such vendor's subcontractors, or EOHHS's contracted Enrollment Broker within a reasonable time. EOHHS may request additional information from the Contractor in order to perform such review.

Section 3.4 Information Systems

EOHHS shall:

A. Cooperate with the Contractor on any system implementation or enhancement necessary to meet the requirements of the Contract that affects either EOHHS's MMIS or the Contractor's MIS through the term of the Contract.

B. Provide technical assistance as necessary for the Contractor to gain access to specified EOHHS systems where such access is required by the Contract.

C. Provide and maintain a list of access codes for all Contractor staff requiring access to EOHHS systems.

D. Assist the Contractor, as necessary, to verify a Covered Individual's eligibility status with the Contractor.

Section 3.5 Marketing

EOHHS shall:

A. Monitor the Contractor's Marketing activities and distribution of related materials; and

B. Within fifteen (15) business days of receipt of Marketing Material submitted by the Contractor in compliance with **Section 2.11.A.3**, take one of the following actions:

1. Approve or disapprove the Marketing Material;

2. Require modification to the Marketing Material; or

3. Notify the Contractor that EOHHS requires an additional ten (10) business days from the date of such notification to take the actions described in **B.1** or **B.2** above.

The Contractor shall comply with any such EOHHS action. EOHHS's failure to take any of the actions described in **B.1, 2 or 3** above within 30 business days after receipt of the Contractor's Marketing Material, shall be deemed to constitute approval of said Marketing Material. Further, EOHHS's failure to take any of the actions described in **B.1 or B.2** above within ten (10) business days after notification of the Contractor in accordance with **B.3**, shall be deemed to constitute approval of the Marketing Material, as shall EOHHS's failure to respond within ten (10) business days of receipt of modifications to Marketing Materials submitted to EOHHS pursuant to **B.2** above.

Section 3.6 Additional Covered Individual Groups

EOHHS may:

A. Develop and implement, in consultation with the Contractor, and other entities such as but not limited to Accountable Care Partnership Plans and MassHealth-contracted MCOs, necessary processes and procedures required to implement enrollment of additional MassHealth Covered Individual groups, as further specified by EOHHS;

B. Develop a Behavioral Health benefit package for any such MassHealth coverage group which to the extent practicable is consistent with Behavioral Health Covered Services for other MassHealth coverage groups;

C. Inform the Contractor regarding demographic characteristics and utilization experience of any new group of Covered Individuals group prior to initiation of enrollment to the extent that such information is available;

D. Develop a Capitation Rate(s) for such Covered Individual group(s) consistent with 42 CFR 447.361 and in consultation with the Contractor; and

E. Develop, in cooperation with the Contractor, an implementation strategy for providing services to Covered Individuals.

Section 4. PAYMENT AND FINANCIAL PROVISIONS

Section 4.1 Rating Categories (RCs) for Covered Individuals

A. RC I (Families) Adults

RC I Adults includes MassHealth Members between the ages of 21 and 65 who are enrolled in MassHealth Standard, including individuals receiving Transitional Aid to Families with Dependent Children (TAFDC) benefits; MassHealth Members who are categorically related to the TAFDC program, (excluding spend-down cases); MassHealth Members between the ages of 21 and 65 under the Refugee Resettlement Program, MassHealth Members in MassHealth (Family Assistance); RC I Adults excludes individuals who have Third-Party Liability coverage.

B. RC I Children (Families)

RC I Children include MassHealth members under the age of 21 who are enrolled in MassHealth Standard, including individuals receiving Transitional Aid to Families with Dependent Children (TAFDC) benefits; MassHealth Members who categorically related to the TAFDC program, (excluding spend-down cases); MassHealth Members from the age of 0 through age 20 under the Refugee Resettlement Program, MassHealth Members in MassHealth (Family Assistance); RC I Children excludes individuals who have Third-Party Liability coverage.

C. RC I Children under 21 with TPL Only

RC I Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard under age 21 with Third- Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

D. RC II (Disabled) Adults

RC II Adults includes: MassHealth Members between the age of 21 and 65 who are disabled and receiving Supplemental Security Income (SSI), excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members who are disabled, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members receiving SSI and Massachusetts Commission for the Blind benefits, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members of the Massachusetts Commission for the Blind excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Standard (Disabled) Members; and Members of MassHealth CommonHealth who have no Third-Party Liability coverage.

E. RC II Children (Disabled)

RC II Children includes: MassHealth Member under the age of 21 who are disabled and receiving Supplemental Security Income (SSI), excluding those individuals who receive

either Medicare Part A or Medicare Part B benefits; MassHealth Members who are disabled, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members receiving SSI and Massachusetts Commission for the Blind benefits, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members of the Massachusetts Commission for the Blind excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Standard (Disabled) Members; and Members of MassHealth CommonHealth who have no Third-Party Liability coverage.

F. RC II Children under 21 with TPL Only

RC II Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard (Disabled) and CommonHealth under age 21 with Third-Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

G. RC IX (CarePlus)

RC IX includes Covered Individuals over the age of 20 and under the age of 65 with incomes up to 133 percent of the Federal Poverty Level (FPL), who are not pregnant, disabled, or a parent or a caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC IX are individuals who are dually-eligible for Medicaid and Medicare.

H. RC X (CarePlus)

RC X includes Covered Individuals over the age 20 and under the age of 65 with incomes up to 133 percent of the FPL, who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. Excluded from RC X are individuals who are pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC X are individuals who are dually eligible for Medicaid and Medicare.

Section 4.2 Payment Provisions and Methodologies

A. Payment for Provision of Covered Services to Covered Individuals

EOHHS shall make payments to the Contractor in accordance with the payment provisions in this Section, including the Behavioral Health Covered Services Capitation Rates, the Administrative Component of the BH Covered Services Capitation Rates, payments made for Risk Sharing, Care Management Payments, and payments made for Performance Incentive Arrangements shall be made in accordance with 42 CFR 438.4-438.8. Except as expressly set forth herein, the Contractor shall accept the payments set forth below as payment in full for the provision of Behavioral Health Covered Services and all other activities described in this Contract.

All payments under this Contract are subject to state appropriation and all necessary federal approvals.

1. Behavioral Health Covered Services Capitation Rates

   EOHHS shall pay the Contractor Behavioral Health Covered Services Capitation Rates for all BH Covered Services provided under this Contract except as set forth in **Section 4.2.A.2** below. All Behavioral Health Covered Services Capitation Rates shall be as set forth in **Appendix H-1**.

2. Exclusions from the Behavioral Health Covered Services Capitation Rates

   EOHHS shall pay the Contractor for services provided by AMCI/YMCI providers to Uninsured Individuals and persons with Medicare only according to the methodology set forth in **Section 4.2.K**.

3. Risk-Sharing Arrangements

   The Contractor and EOHHS may share financial risk for Behavioral Health Covered Services. Risk sharing arrangements shall be as set forth in **Section 4.6** and **Appendix H-1**.

4. Administrative Component of the Behavioral Health Covered Services Capitation Rate and Care Management Program.

   a. EOHHS shall pay the Contractor an Administrative Component of the Behavioral Health Covered Services and Care Management Program Capitation Rate for each Contract Year as set forth in **Appendix H-1**.

   b. The Administrative Component of the Behavioral Health Covered Services Capitation Rate shall be based on a Per Member (Covered Individual) Per Month (PMPM) rate that is determined using the Covered Individuals served under the Contract.

5. Performance Incentive Arrangements

   EOHHS and the Contractor may establish Performance Incentive Arrangements. If such Performance Incentive Arrangements are established, EOHHS shall pay the Contractor Performance Incentive Arrangement payments based on EOHHS's assessment of the Contractor's achievement of such Performance Incentives and all terms and conditions for payment as set forth in this Contract and **Appendices G** and **H-1**. Any such incentive payment shall not result in payments in excess of 105 percent of the approved Capitation Payments.

6. PCC Plan Management Support Services

   EOHHS shall pay the Contractor for the PCC Plan Management Support Services activities described in **Section 2.19** and other Sections of the Contract, as identified by the parties each Contract Year, as set forth in **Appendix H-1**.

The PCC Plan Management Support payments shall be based on a fixed rate plus an additional Per Member (Enrollee) Per Month (PMPM) rate that is determined using the number of Enrollees in the PCC Plan above a set number of Enrollees identified in **Appendix H-1**. In its discretion, at any time, EOHHS may review with the Contractor the PCC SS PMPM rate based on significant changes in enrollment, case mix, or other factors. EOHHS may change the fixed and the additional PMPM amount consistent with **Section 4.2.H. and Appendix H-1**.

7. Payment for Provision for ASD-ID and EC MCPAP Programs

   EOHHS shall pay the Contractor to provide the ASD-ID, EC MCPAP Programs. Such payments shall be set forth in **Appendix H-1**.

8. Payment for Crisis Service Safety Net Initiative

   EOHHS shall pay the Contractor to administer the Crisis Service Safety Net Initiative. Such payments shall be set forth in **Appendix H-1**.

9. Payment for MOUD Access and Pain Management Support

   EOHHS shall pay the Contractor to provide MOUD Access and Pain Management Support services. Such payments shall be set forth in **Appendix H-1.**

10. Contractor's Use of Earnings for Compliance with Financial Stability Requirements

    In no event shall any portion of the any payments made under this Contract, other than earnings, be used to pay the Contractor's cost for compliance with financial stability provisions (**Section 2.15**).

B. Modification of Covered Services

If, at any time during the term of the Contract, EOHHS directs the Contractor to eliminate or modify BH Covered Services, the Contractor shall accept a modification in Behavioral Health Covered Services Capitation Rates which shall be calculated by EOHHS in consultation with the Contractor.

C. Periodic Rate Review

In its discretion, at any time, EOHHS may review with the Contractor BH Covered Services Capitation Rates and the other financial provisions of this Contract to determine if such provisions should be adjusted due to changes in enrollment, case mix, or other factors. To the extent required by applicable federal law, such payment adjustments shall comply with the principles of actuarial soundness as determined by EOHHS in accordance with 42 CFR 438.4. In the event that EOHHS performs such a Periodic Rate Review and proposes modifications to any financial provisions as a result, the Contractor shall have 60 days to accept such modifications. In the event that the Contractor does not accept the financial provisions within 60 days, EOHHS may terminate the Contract and

the provisions of **Section 5.5** shall apply.

D. Adjustment of Compensation

Notwithstanding anything herein to the contrary, in the event of a material change in the scope of Contractor's obligations under this Agreement, including but not limited to a modification of Covered Services, change in applicable law, regulation, accreditation guidelines, policy, process or procedure, or other requirements, ability to perform utilization review, Member enrollment, case mix or other factors, that materially affects Contractor's obligations under this Agreement, Contractor may provide written notice thereof to EOHHS, and the parties shall negotiate in good faith an appropriate adjustment to the compensation to be paid under this Agreement. Such good faith negotiation shall conclude no later than sixty (60) days from the commencement thereof.

E. Annual Negotiation of Financial Terms

In determining the financial terms of the Contract, the Contractor shall meet with EOHHS annually to renegotiate the financial terms for each Contract Year. Such meetings shall begin no later than three months before the end of each Contract Year. EOHHS shall incorporate annual financial terms into the Contract as **Appendix H-1**.

F. Failure to Accept Financial Provisions

1. In the event that the Contractor does not accept financial provisions for the next Contract Year at least 21 days before the start of the new Contract Year, EOHHS shall continue to pay the Contractor under the current year's financial provisions and the Contractor shall accept such payment as payment in full under the Contract subject to **subsections a and b below**. In the event that any component of the current year's financial provisions is outside the actuarially sound range for the new Contract Year as determined by EOHHS' actuaries, then EOHHS shall pay the Contractor within the actuarially sound range for the new Contract Year, and the Contractor shall accept such payments as payment in full under the Contract subject to **subsections a and b** below. EOHHS may halt all new Enrollee assignments into the PCC Plan until the Contractor accepts the financial provisions offered by EOHHS.

    a. In the event that the payments made under **Section 4.2.F.1** are higher than the financial provisions for the new Contract Year that the Contractor ultimately accepts, EOHHS may recoup the higher payments made during the interim period.

    b. In the event that the payments made under **Section 4.2.F.1** are lower than the financial provisions for the new Contract Year that the Contractor ultimately accepts, EOHHS will not retroactively adjust the lower payments made during the interim period.

c. In the event that the Contractor does not accept the financial provisions within 60 days of EOHHS's offer, EOHHS may terminate the Contract in accordance with **Section 5.5** and the Contractor shall be obligated to continue to perform all obligations under the Contract as described in **Section 5.5.C**, until such time as all Covered Individuals are disenrolled from the Contractor's plan. The Contractor shall accept the lower of the prior year's financial provisions or the financial provisions EOHHS offered for the current year as payment in full during this time period.

G. Monthly Estimated BH Covered Services Capitation Rate Payment Process

1. Each month EOHHS shall pay the Contractor an Estimated Capitation Payment, which will include the BH Covered Services Capitation Payment, in accordance with the following methodology. EOHHS shall:

a. Determine the BH Covered Services Capitation Rates Per-Covered Individual per month (PMPM) rate for each RC.

b. Multiply the estimated number of Covered Individuals for the month, as determined by EOHHS in each RC, by the PMPM amount for the RC.

c. Sum the calculations for each RC; this is the Estimated Monthly BH Covered Services Capitation Amount.

d. For Covered Individuals for whom EOHHS has assigned a specific disenrollment date due to a qualifying event such as a member attaining age 65 within the Payment Month, EOHHS shall make a pro-rated Estimated Capitation Payment to the Contractor. The pro-rated Estimated Capitation Payment will equal:

1) The Behavioral Health Covered Services Capitation Rate,

2) Multiplied by the number of Enrollee Days during the Payment Month

3) Divided by the total number of days in the Payment Month.

H. Methodologies for Administrative Component of BH Capitation Rate

1. Estimated Monthly Administrative Payments

Each month EOHHS shall pay the Contractor an Estimated Administrative Payment, which will include the care management administrative rate, in accordance with the following methodology. EOHHS shall:

a. Determine the estimated number of Covered Individuals in the month.

b. Multiply the estimated number of Covered Individuals, as determined by EOHHS, by the PMPM rate; this is the Estimated Monthly Administrative Component of the BH Covered Services Capitation Rate amount.

I. Methodology for PCC Plan Management Support Services

Each month EOHHS shall pay the Contractor an Estimated PCC Plan Management Support Services Payment. The applicable PMPM Plan management support rate will be based in part on the number of Enrollees in the PCC Plan, as further described in **Appendix H-1**.

J. Payment for Provision of Services by Indian Health Care Providers to Indian Enrollees

1. All payments to the Contractor are conditioned on compliance with the provisions below, 42 CFR 438.14, and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. The Contractor shall:

    a. Permit Indian Covered Individuals to obtain BH Covered Services from out-of-network Indian Health Care Providers from whom the Covered Individual is otherwise eligible to receive such services. The Contractor shall also permit an out-of-network Indian Health Care Provider to refer an Indian Covered Individual to a Network Provider;

    b. Demonstrate that it has sufficient access to Indian Health Care Providers to ensure that Indian Covered Individuals have timely access to BH Covered Services from such providers;

    c. Pay both network and non-network Indian Health Care Providers who provide BH Covered Services to Indian Covered Individuals a negotiated rate which shall be no lower than the MassHealth fee for service rate for the same service or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is greater, or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the BH Covered Service provided by a non-Indian Health Care Provider or the MassHealth fee for service rate for the same service, whichever is greater;

    d. Make prompt payment to Indian Health Care Providers; and

    e. Pay non-network Indian Health Care Providers that are Federally Qualified Health Centers (FQHCs) for the provision of services to an Indian Covered Individual at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 CFR 438.14(c)(1).

K. Other Provider Payment Provisions

The Contractor shall ensure the following payment provisions are met:

1. Payments to FQHCs and Rural Health Centers (RHCs) for services to Covered Individuals are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay

FQHCs and RHCs at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 101 CMR 304.04, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

2. For all allowable individual mental health visits (as defined in 101 CMR 304.02) furnished at FQHCs and RHCs, the Contractor shall use the Health Care Common Procedure Codes (HCPC), G0469 and G0470, and T1040 and TI040-HQ,for new and established patients respectively, specified in 101 CMR 304.00, et seq., and shall use no alternative codes for the same or similar services.

3. 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 in 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.

L. Payment Provisions for AMCI and YMCI services for Uninsured Individuals and Persons with Medicare Only

1. General Provisions

The Contractor shall:

a. For AMCI and YMCI services for Uninsured Individuals and persons with Medicare only, require CBHCs to bill other insurances (TPL), where available and consistent with **Section 2.18**, and the Health Safety Net in accordance with applicable law.

b. Pay CBHCs the rate for AMCI and YMCI services established by the EOHHS and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to CBHCs for AMCI and YMCI services for Uninsured Individuals and persons with Medicare only delivered under the Contract.

c. Not utilize the AMCI Amount except to pay for AMCI and YMCI services delivered to Uninsured Individuals and persons with Medicare only

d. For dates of service on January 1 and 2, 2023, or as otherwise directed by EOHHS, pay ESP providers for ESP and MCI services provided to Uninsured Individuals and persons with Medicare only, in accordance with **Appendix A-4**.

2. Payment Methodology

a. EOHHS shall annually provide the Contractor with an estimated amount it expects to pay each CBHC for AMCI and YMCI services delivered on a Fee-for-Service basis by EOHHS.

b. The Contractor shall provide EOHHS with an annual report of the Contractor's estimate of the total amount it expects to pay for AMCI and YMCI services, including both BH Covered Services and DMH Specialty Program delivered under the Contract.

c. Based on the Contractor's estimate of the amount it expects to pay for such AMCI and YMCI services, EOHHS shall establish an AMCI and YMCI Amount for Uninsured Individuals and persons with Medicare only.

d. The AMCI and YMCI Amount shall be in accordance with **Appendix H-1**. The Contractor shall develop a plan to monitor and report on, throughout each Contract year, AMCI and YMCI expenditures for Uninsured Individuals and persons with Medicare only compared to the amount in **Appendix H-1**. Such report shall also include monitoring of AMCI and YMCI expenditures for Covered Individuals.

e. Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for AMCI and YMCI services until it has received funding from DMH in the amounts necessary to make any such payments.

M. Payment Provisions for ED-based Behavioral Health Crisis Evaluation services for Uninsured Individuals and Persons with Medicare Only

The Contractor shall:

1. For ED-based Behavioral Health Crisis Evaluation services for Uninsured Individuals and persons with Medicare only, require hospitals to bill other insurances (TPL), where available and consistent with **Section 2.18**, and the Health Safety Net in accordance with applicable law.

2. Pay hospitals the rate for ED-based Behavioral Health Crisis Evaluation services established by the EOHHS and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to hospitals for ED-based Behavioral Health Crisis Evaluation services for Uninsured Individuals and persons with Medicare only delivered under the Contract.

N. Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP)

1. Each state fiscal year, the Contractor shall pay each contracted CBHC an annual base rate as defined in **Appendix H-1** for its operation of the MCI/RAP. The base rate shall include all administrative cost including:

a. Staff recruitment;

b. Staff reimbursement including fringe and benefits where applicable;

c. Scheduling;

d. Training;

e. Outreach to police and ALPs;

f. Follow-up with police/ALPs;

g. Coordination as needed with probation;

h. Coordination as needed with United Way 211, or other 24/7 information and referral provider; and

i. Documentation reporting requirements including but not limited to submission of quarterly data.

2. The Contractor shall pay the base rate annually.

3. The Contractor shall make these payments, and shall account for any other costs associated with operation of the MCI/RAP, using only the payments EOHHS provides the Contractor in accordance with **Section 2.7.I.6** and the Contractor's own funds. The Contractor shall not use any other payments EOHHS provides the Contractor to operate the MCI/RAP. Unless specifically directed to do so by EOHHS, the Contractor shall not include the Contractor's costs and expenditures related to the MCI/RAP in its Encounter Data submitted to EOHHS and such costs and expenditures shall not be considered when calculating any payment pursuant to the risk sharing arrangement in **Section 4.6** and **Appendix H-1**.

O. Payments for the Department of Public Health Emergency Department Boarding Reduction Grant Initiatives

1. EOHHS shall issue payments to the Contractor, in an amount and frequency specified in **Appendix H-1,** in support of DPH Emergency Department (ED) Boarding Reduction Grant Initiatives aimed at reducing the amount of time individuals wait in EDs for disposition to a 24-hour level of BH care.

a. The Contractor shall expend the amount described in **Appendix H-1**, to provide grants to reduce the amount of time individuals wait in EDs for disposition to a 24-hour level of BH care through staffing investments and rate incentives associated with fully operationalizing community based acute treatment.

b. The Contractor shall fund staffing investments for culturally and linguistically-competent workforce recruitment, retention and training, such as hiring and retention incentives and loan repayment programs; and

c. The Contractor shall give priority to grants that support new beds that would be located in underserved areas of the Commonwealth.

Section 4.3 Payment Reconciliation Process

A. Enrollment-related Reconciliations

1. Monthly BH Covered Services Capitation Amount Reconciliation Process

a. EOHHS shall perform a monthly reconciliation of the Estimated Monthly BH Covered Services Capitation Payment Amount against the actual number of Covered Individual months by RC, as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

1) Multiply the actual number of Covered Individual months, as determined by EOHHS for each RC for the previous month, by the PMPM amount for each RC.

2) Sum the calculations for each RC described in **subsection a**; this is the Actual Monthly BH Covered Services Capitation Amount.

3) Compare the sum of the Estimated Monthly BH Covered Services Capitation Payment paid for the month against the Actual Monthly BH Covered Services Capitation Amount. This reconciliation shall occur monthly.

2. Estimated Monthly BH Covered Services Administrative Reconciliation Process

a. EOHHS shall perform a monthly reconciliation of the Estimated Monthly Payment for Administrative Component of the BH Covered Services Capitation Rate calculated according to **Section 4.3.A.2** against the actual number of Covered Individuals as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

1) Multiply the actual number of Covered Individuals for the previous month, by the PMPM BH Administrative rate and the Care Management administrative rate amount; this is the Actual Monthly Administrative Component of the BH Covered Services Capitation Rate.

2) Compare the Estimated Monthly Administrative Component of the BH Covered Services paid for the month against the Actual Monthly Administrative Component of the BH Covered Services Capitation Rate.

3. Estimated PCC PMSS Payment Process

a. Each month EOHHS shall issue monthly payments to the Contractor for PCC Plan Management Support Services, in accordance with the following methodology. EOHHS shall:

1) Determine the number of PCC Enrollees for the month using the monthly enrollment file used to generate prospective capitation.

2) Multiply the number of Enrollees for the month, as determined by EOHHS, by the applicable PMPM Plan management support rate; this payment will be the final Monthly PCC Plan Management Support Services Payment Amount applicable to the number of enrollees for the month.

4. The Contractor shall provide any information necessary to complete monthly and annual payment reconciliations in the time frame and format specified by EOHHS for Estimated BH Covered Services Capitation Rates, Estimated Monthly Administrative Component of the BH Covered Services, and Estimated PCC PMSS Payments.

a. Based on the comparisons described in **subsection 1, 2 , and 3** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

1) EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly BH Covered Services Capitation Rates, Estimated Monthly Administrative Component of the BH Covered Services, and future Estimated PCC PMSS Payments as applicable, or by another mechanism, as determined by EOHHS.

2) The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to Estimated Covered Services Capitation Rates, Estimated Monthly Administrative Component of the BH Covered Services, and future Estimated PCC PMSS Payments, as applicable, or by another mechanism, as determined by EOHHS.

B. Reconciliation Process for AMCI and YMCI services Provided to Uninsured Individuals and Persons with Medicare Only

1. By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report (see **Appendix E-1**) of the Contractor's actual expenditures for AMCI and YMCI services provided to Uninsured Individuals and persons with Medicare only, based on Claims paid through no later than 180 days, including its best estimate of IBNR Claims and any applicable IBNR completion factor reported to EOHHS.

2. EOHHS shall conduct a year-end reconciliation of the Contractor's estimated expenditures on AMCI and YMCI services provided to Uninsured Individuals and

persons with Medicare only delivered under the Contract against actual expenditures, including IBNR.

3. If actual expenditures are less than the Contractor's estimates, EOHHS shall recoup the difference from the Contractor.

4. If actual expenditures are greater than the Contractor's estimate, EOHHS shall pay the difference to the Contractor.

5. The Contractor and EOHHS shall perform the reconciliation set forth in this Section for ESP services provided to Uninsured Individuals and individuals with Medicare only on January 1 and 2, 2023 and as further specified by EOHHS.

Section 4.4 BH Covered Services Continuing Services Reconciliation

EOHHS shall perform a year-end Continuing Services reconciliation as follows:

A. The Contractor shall process and pay its Providers' Claims for all Continuing Services at the Contractor's contracted rate with its Providers.

B. EOHHS shall perform a reconciliation following the end of the Contract Year to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by BOH and which were provided following the conclusion of the Internal Appeal ("approved Continuing Service claims"); provided that the Contractor submits to EOHHS by 210 days following the end of the Contract Year all data regarding such services, as required in **Appendix E-1**.

C. EOHHS shall pay the Contractor no later than 60 days following the reconciliation set forth in **subsection B** the total value of the approved Continuing Service claims referenced in **subsection B** that were provided in the applicable Contract Year; provided that the Contractor timely submitted all data required by EOHHS pursuant to **Appendix E-1**.

D. Approved Continuing Service claims shall include, at a minimum, the following information:

1. Covered Individuals information, by MID, including date of birth, sex, dates of enrollment, the dates on which the Continuing Services were provided, and current enrollment status;

2. Costs incurred, by MID, including dates of service; and

3. Such other information as may be required pursuant to any EOHHS request for information.

E. The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Covered Individuals by the Contractor. 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 herein.

Section 4.5 In-State Acute Hospital Add-on/Pursuant to Section 2.7.F.3.J

A. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of provider payments described in **Section 2.7.F.3.J** for the applicable time period.

B. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year, of the directed payments described in **Section 2.7.F.3.J.** EOHHS shall remit to the Contractor the full amount of any underpayments it identifies. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments described in **Section 4.5**

Section 4.6 Performance Incentive Arrangements

A. EOHHS may establish annual performance standards and financial sanctions or incentive arrangements in **Appendix G** for the Contractor related to its performance of Contractor responsibilities. EOHHS shall determine whether the Contractor has met, exceeded, or fallen below any and all such performance standards and shall provide the Contractor with written notice of such determinations.

B. In no case shall total payments to the Contractor exceed 105% of the Contractor-specific Capitation payments, as determined by EOHHS.

C. All Performance Incentive arrangements shall meet the following requirements:

1. Performance Incentives shall be for a fixed period of time, which shall be described in the specific Performance Incentive;
2. No Performance Incentive shall be renewed automatically;
3. All Performance Incentives shall be made available to both public and private contractors;
4. No Performance Incentive shall be conditioned on intergovernmental transfer agreements;
5. All Performance Incentives shall be necessary for the specified activities, targets, and performance measures or quality-based outcomes that support program initiatives as specified by the state's quality strategy under 42 CFR 438.340; and
6. The Contractor's performance under any Performance Incentive shall be measured during the Contract Year in which the Performance Incentive is effective.

Section 4.7 Risk-Sharing Arrangements

A. General Provisions

1. There may be distinct financial risk-sharing arrangements for the Behavioral Health Covered Services Component of the Capitation Rates paid for under the Rates for RC I excluding Children under 21 with TPL; RC I Children under 21 with TPL only; RC II excluding Children under 21 with TPL; RC II Children under 21 with TPL only; and RC IX and RC X, as applicable, as set forth in **Appendix H-1**.

2. The arrangement described in this **Section 4.6** may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.

3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor's expenditures related to Covered Individuals, as determined by EOHHS.

4. The Contractor's Behavioral Health Covered Services Capitation Rate revenue shall mean the sum of the applicable 12 Actual Monthly Behavioral Health Covered Services Capitation Rate payments for the Contract Year, as determined in accordance with **Section 4.2.A**. This calculation shall be used to determine the Contractor's revenue for the Behavioral Health Covered Services Capitation Rate.

5. By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report of actual expenditures for all of the services included in the Behavioral Health Covered Services Capitation Rate, subtracting any TPL recoveries retained by the Contractor pursuant to **Section 2.18**. The report of expenditures shall be based on all Claims paid through no fewer than 180 days, including the Contractor's best estimate of Claims incurred but not reported (IBNR) and any applicable IBNR completion factor reported to EOHHS with the IBNR methodology report (see **Appendix E-1**). In the event that the above final report of actual expenditures includes an IBNR completion factor greater than 1 percent for total BH Covered Services, EOHHS reserves the right to conduct an audit of the Contractor's IBNR methodology.

6. EOHHS shall in its sole discretion make the final determination of IBNR, using the Contractor's report of actual expenditures to inform that determination.

7. EOHHS shall compare the actual PMPM Behavioral Health Covered Services Capitation Rate payments for the Contract Year to the Contractor's actual expenditures. Based on such comparison, and calculating any difference, EOHHS shall determine in accordance with **Section 4.4** whether overpayments or underpayments were made to the Contractor.

a. If underpayments were made, EOHHS shall pay the Contractor a final payment for the preceding Contract Year in accordance with the methodology.

b. If overpayments were made the Contractor shall pay EOHHS a final payment for the preceding Contract Year in accordance with the methodology.

8. Notwithstanding the generality of the foregoing, if EOHHS determines that risk sharing arrangements result in payments that exceed the approved capitation rates and the excess payments exceed that total amount MassHealth would have paid on a fee for service basis for the BH Covered Services actually furnished to Covered Individuals, EOHHS may re-price any or all of the Contractor's paid Claims so that the total final payments to the Contractor based on risk sharing arrangements do not exceed the amount MassHealth would have paid for the actual services provided to Covered Individuals on a Fee-For-Service basis.

B. Primary Care ACO

1. There may be distinct risk-sharing arrangements for the services delivered to a Covered Individual enrolled in a Primary Care ACO as set forth in **Appendix H-1**.

2. The arrangement described in this Section may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.

3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor's expenditures related to Covered Individuals enrolled in a Primary Care ACO, as determined by EOHHS.

C. Applied Behavioral Analysis and Substance Use Disorders

There may be distinct and limited risk-sharing arrangements for the Applied Behavioral Analysis and SUD Level 3.1 and 3.3 services as set forth in **Appendix H-1**.

Section 4.8 Reinsurance

The Contractor may purchase reinsurance from a company authorized to do business in Massachusetts, to cover medical costs that exceed a threshold per Covered Individual for all rating categories for the duration of the Contract period. Such reinsurance policy is not required and is at the Contractor's discretion.

Section 4.9 Option to Audit

EOHHS, or its authorized agent, may perform an audit to verify any claims data submitted by the Contractor. The findings of such audit shall determine the amount, if any, that the Contractor

shall be reimbursed or that EOHHS shall recover from the Contractor. If an audit is not conducted, EOHHS shall, within a reasonable time after receipt of claims data from the Contractor and in accordance with any applicable timeframe described in the Contract, reimburse to the Contractor or recover from the Contractor as provided in the reconciliation processes described in this **Section 4**.

Section 4.10 Behavioral Health Quality Incentive Payment

A. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of the provider payments described in **Section 2.7.F.4** for the applicable time period.

B. For each Contract Year, EOHHS shall perform an annual reconciliation after the end of the Contract Year to correct the amount of payments described in **Section 2.7.F.4**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

Section 4.11 Clinical Quality Incentive for Acute Hospitals

A. At a frequency to be specified by EOHHS, EOHHS shall pay the Contractor an amount equal to the sum of the provider payments described in **Section 2.7.F.5** for the applicable time period.

B. For the performance period, EOHHS shall perform a reconciliation after the end of the performance period to correct the amount of payments described in **Section 2.7.F.5**. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies.

Section 5. ADDITIONAL TERMS AND CONDITIONS

Section 5.1 Administration

A. Notification of Administrative Changes

The Contractor shall notify EOHHS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor shall notify EOHHS in writing no later than 60 days prior to any material change to the manner in which services are rendered to Covered Individuals, including but not limited to reprocurement or termination of a Material Subcontractor. The Contractor shall notify EOHHS in writing, of all other changes no later than five business days prior to the effective date of such change. The Contractor shall notify EOHHS in writing no later than 90 days prior to the effective date of any material administrative and operational change with respect to the Contractor**,** including but not limited to a change to the Contractor's corporate structure, ownership, or tax identification number.

B. Assignment or Transfer

The Contractor shall not assign or transfer any right or interest in this Contract to any successor entity or other entity, including any entity that results from a merger of the Contractor and another entity, without the prior written consent of EOHHS. The Contractor shall include in such request for approval a detailed plan for EOHHS to review. The purpose of the plan review is to ensure uninterrupted services to Covered Individuals, evaluate the new entity's ability to support the Provider Network, ensure that services to Covered Individuals are not diminished and that major components of the organization and EOHHS programs are not adversely affected by the assignment or transfer of this Contract.

C. Independent Contractors

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

D. Subrogation

Subject to EOHHS's lien and third party recovery rights, the Contractor shall:

1. Be subrogated and succeed to any right of recovery of a Covered Individual against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder; and

2. Require that the Covered Individual 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, pursuant to the third-party liability benefit

coordination plan to be implemented under the provisions of **Section 2.18**. The Contractor may ask the Covered Individual:

a. To 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 to take no action prejudicing the rights and interest of the Contractor hereunder; and

b. To notify the Contractor hereunder and to 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. Advance Directives

The Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The Contractor shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

F. Compliance with Certification, Program Integrity and Prohibited Affiliation Requirements

As a condition of receiving payment under this Contract, the Contractor must comply with all applicable certification, program integrity and prohibited affiliation requirements at 42 CFR 438.600 et seq., and as described in this Contract**.**

G. Prohibited Affiliations and Exclusion of Entities

1. In accordance with 42 U.S.C. § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting, provider, subcontractor, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under the Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded from certain procurement and non-procurement activities, under federal or state law, regulation, executive order or guidelines. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity nor be permitted to serve as a director, officer, or partner of the Contractor. The Contractor shall provide written disclosure to EOHHS of any prohibited affiliations identified by the Contractor.

2. The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b).

H. Subcapitation and Physician Incentive Plans

1. The Contractor may, subject to EOHHS's prior review and approval and all applicable state and federal rules and regulations, including but not limited to the provisions of 42 CFR 438.3(i), 42 CFR 422.208 and 422.210, negotiate and enter into arrangements to pay Network Providers on a subcapitated basis or operate a physician incentive plan.

2. The Contractor shall not engage in risk-sharing payment methodologies (i.e., non-Fee-for-Service arrangements) with its Network Providers without first submitting the proposed payment methodology to EOHHS for review and approval. Any Network Provider payment methodology that the Contractor proposes to EOHHS must satisfy the following minimum requirements:

   a. Balance cost incentives with access and quality incentives; and

   b. Ensure that those Network Providers for whom the Contractor proposes to use such payment methodologies are able to demonstrate the managerial, operational and financial capability to manage the proposed risk arrangement.

3. The Contractor shall comply, and shall ensure that its subcontractors comply, with all applicable requirements governing subcapitation arrangements and physician incentive plans. In accordance with the requirements of 42 U.S.C. § 1396b(m)(2)(A)(x), 42 CFR Parts 417, 422, 434, 438, and 1003, the Contractor shall ensure that:

   a. No specific payment is made directly or indirectly to a Provider, physician, or physician group as an inducement to reduce or limit Medically Necessary services furnished to a Covered Individual; and

   b. The applicable stop-loss protection, Covered Individual survey, and disclosure requirements of 42 CFR Part 417 are met.

I. National Provider Identifier

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

J. Provider-Covered Individual Communications

1. In accordance with 42 USC 1396u-2(b)(3) and 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Individual who is his or her patient, for the following:

a. The Covered Individual's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

b. Any information the Covered Individual needs in order to decide among all relevant treatment options;

c. The risks, benefits, and consequences of treatment or non-treatment; and

d. The Covered Individual's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2. Notwithstanding the provisions of **Section 5.1.J.1** above, and subject to the requirements set forth below, the Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if the Contractor objects to the service on moral or religious grounds. The Contractor must furnish information about any service the Contractor does not cover due to moral or religious grounds as follows.

a. EOHHS:

1) With its application for a Medicaid contract; and

2) At least 60 days prior to adopting the policy during the term of the Contract.

b. To Potential Covered Individuals, via enrollment/Marketing materials, at least 30 days prior to adopting the policy during the term of the Contract.

c. To Covered Individuals, at least 30 days prior to adopting the policy during the term of the Contract and in the Covered Individual handbook. The Contractor shall also describe in the Covered Individual handbook that the Covered Individual may access such services by contacting MassHealth directly and provide contact information.

3. The Contractor shall accept a reduction in the Capitation Rate for any service it does not provide, reimburse for, or provide coverage of due to moral or religious grounds.

K. Covered Individuals - No Liability for Payment

1. The Contractor shall:

a. Ensure, in accordance with 42 USC §1396 u-2(b)(6) and 42 CFR 438.106, that a Covered Individual will not be held liable:

1) For debts of the Contractor, in the event of the Contractor's insolvency;

2) For services (other than Excluded Services) provided to the Covered Individual in the event that:

a) The Contractor fails to receive payment from EOHHS for such services; or

b) A Provider fails to receive payment from EOHHS or the Contractor for such services, including but not limited to payments that are in excess of the amount the covered individual would owe if the Contractor covered the service directly.

b. Not charge Covered Individuals coinsurance, co-payments, deductibles, financial penalties or any other amount in full or part, for any service provided under this Contract.

c. Not deny any service provided under this Contract to a Covered Individual who, prior to becoming MassHealth eligible, incurred a debt that has not been paid.

d. Ensure Provider compliance with all Covered Individual payment restrictions, including balance billing and co-payment provisions, and develop and implement a plan to sanction any Provider that does not comply with such provisions.

e. Return to the Covered Individual the amount of any liability inappropriately imposed on and paid by the Covered Individual.

L. Covered Individual Rights

1. The Contractor must have written policies regarding Covered Individual rights and must comply with any applicable federal and state laws that pertain to Covered Individual rights;

2. The Contractor must ensure that its staff and affiliated Providers take those rights into account when furnishing services to Covered Individuals;

3. Covered Individual rights shall include:

a. The right to receive the information required pursuant to this Contract;

b. The right to be treated with respect and with due consideration for his or her dignity and privacy;

c. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Covered Individual's condition and ability to understand;

d. The right to receive a second opinion on a medical procedure and have the Contractor pay for such second opinion consultation visit;

e. The right to participate in decisions regarding his or her health care, including the right to refuse treatment;

f. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

g. The right to freely exercise his or her rights without adversely affecting the way the Contractor and its Providers treat the Covered Individual;

h. The right to request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526; and

i. The right to be furnished ACO Covered Services in accordance with this Contract.

M. Coverage of Emergency, Screening and Post-Stabilization Services

1. The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition in accordance with 42 CFR 438.114 and M.G.L. c. 118E, § 17A.

2. The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition regardless of whether the Provider that furnishes the services has a contract with the Contractor.

3. The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition, including cases in which the absence of immediate medical attention would not have:

   a. placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

   b. resulted in serious impairment to bodily functions; or

   c. resulted in serious dysfunction of any bodily organ or part.

4. The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition if a representative of the Contractor instructed the Covered Individual to seek Emergency services.

5. The Contractor may not limit what constitutes a Behavioral Health Emergency medical condition on the basis of lists of diagnoses or symptoms;

6. The Contractor may require Network Providers to notify the Covered Individual's PCC of the Covered Individual's screening and treatment, but may not refuse to cover MassHealth Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition based on their failure to do so;

7. A Covered Individual who has an Emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient;

8. The attending emergency physician, or the Provider actually treating the Covered Individual, is responsible for transfer or discharge, and that determination is binding on the Contractor, if such transfer or discharge order:

   a. is consistent with generally accepted principles of professional medical practice; and

   b. is a covered benefit under the Contract.

9. The Contractor shall cover and pay for Post-stabilization Care Services that are MassHealth Covered Services in accordance with 42 CFR 438.114, 42 CFR 422.113(c), and M.G.L. c. 118E, § 17A.

N. Restraint and Seclusion

The Contractor shall require any Provider that is a psychiatric residential treatment facility providing inpatient psychiatric services to individuals under age 21, to comply with all requirements relating to restraint and seclusion as set forth in 42 CFR 441.151 subpart D, and 42 CFR 483 subpart G and in **DMH's Human Rights and Restraint and Seclusion Policy**.

O. Disclosure Requirements

1. Except as otherwise provided elsewhere in this Contract, the Contractor shall within two business days disclose to EOHHS any known non-compliance by the Contractor with any provision of this Contract, or any state or federal law or regulation governing this Contract.

2. The Contractor shall make the following federally required disclosures in accordance with 42. CFR § 455.100-106, 42 CFR 455.436, 42 CFR 1002.3. and 42 U.S.C. § 1396b(m)(4) in the form and format specified by EOHHS, at any time upon a written request by EOHHS, and as follows:

   a. Ownership and Control

      Upon execution, renewal or extension of this Contract and within 35 days of any change in ownership, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.104 regarding ownership and control, with respect to both the Contractor and Material Subcontractors.

   b. Business Transactions

      Pursuant to 42 CFR 455.105, within 35 days of a written request by EOHHS and/or the U.S. Department of Health and Human Services, the

Contractor shall furnish full and complete information to the requester regarding business transactions.

c. Criminal Convictions

Pursuant to 42 CFR 455.106, upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS regarding persons convicted of crimes.

d. Other Disclosures

The Contractor shall comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. Pursuant to 42 U.S.C. § 1396b(m)(4)(B), the Contractor shall make any information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to Covered Individuals upon reasonable request.

3. The Contractor shall ensure that its Network Provider enrollment forms require Provider applicants to disclose complete ownership, control, and relationship information, and that Network Applicants and Network Providers fully and accurately complete the required portions of the EOHHS form developed for such purpose. Further, the Contractor shall require persons with an ownership or control interest, or persons who are agents or managing employees of Network Providers, to utilize the EOHHS form developed for such purpose to fully and accurately disclose health care-related criminal convictions, and to notify EOHHS of such disclosures within 20 working days.

4. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Section 5.1.O**, the Contractor shall fully and accurately complete the EOHHS form developed for such purpose, attached hereto as **Appendix B-3**. EOHHS may update or replace this Appendix without the need for a Contract amendment.

5. The Contractor shall search the federal HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the System Award Management website for the names of Network providers upon enrollment, reenrollment, credentialing or re-credentialing, as further described in **Section 2.8.H**. In addition, the Contractor shall conduct such searches for the names of Network providers, persons with ownership or control interest in the Contractor, and agents or managing employees of the Contractor at least monthly to ensure that EOHHS does not pay for services provided by excluded persons or entities.

6. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 5.1** or in response to the information contained in the Contractor's disclosures under this **Section 5.1**. In addition, the

Contractor shall not be entitled to payment for any MassHealth services for which EOHHS determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238, et seq. to impose sanctions.

Section 5.2 Data Privacy and Security (including Health Insurance Portability and Accountability Act (HIPAA))

A. The Contractor shall be required to comply with M.G.L. c. 66A, M.G.L. c. 93H, the Health Insurance Portability and Accountability Act ("HIPAA") privacy and security regulations at 45 CFR Parts 160, 162 and 164 (the "HIPAA Rules"), as applicable to a business associate (as such term is used therein), Commonwealth Security Policies issued by the Executive Office of Technology Services and Security and any other applicable laws, regulations, policies, and procedures pertaining to the privacy or security of confidential information that is used, accessed, received, created, maintained, disclosed, transmitted or otherwise obtained by such Contractor or its agents or subcontractors in the course of providing the services described herein, and the Contractor shall be required to enter into any contract or agreement deemed necessary or appropriate by EOHHS to comply with such obligations. For purposes of the foregoing, "confidential information" includes personal data (as such term is used in M.G.L. 66A), personal information (as such term is used in M.G.L. 93H), protected health information (as such term is used in the HIPAA Rules), EOHHS security procedures, business operations information, proprietary information or other information treated that is treated as confidential under applicable law, regulation, policy or contract. Further, EOHHS reserves the right to add any requirement during the course of the Contract that it determines it must include in the contract in order for the department to comply with the HIPAA Rules, M.G.L. c. 66A, 801 CMR 3.00, M.G.L. c. 93H, 201 CMR 17, 42 CFR Part 431, Subpart F, 42 CFR Part 2, 45 CFR §155.260 and other applicable laws, regulations, and policies.

B. Covered Entities

EOHHS and the Contractor acknowledge that they are covered entities, as defined at 45 CFR 160.103.

C. Statutory Requirements

The Contractor shall comply with all applicable requirements regarding the privacy, security, use and disclosure of personal data (including protected health information, such as medical records and any other health and enrollment information), including, but not limited to, requirements set forth in M.G.L. c. 66A, 42 CFR 431, Subpart F, and 45 CFR Parts 160, 162 and 164.

D. Contractor's Compliance with HIPAA

The Contractor represents and warrants that:

1. It shall conform to the requirements of all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations;

2. It shall work cooperatively with EOHHS on all activities related to ongoing compliance with HIPAA requirements, as directed by EOHHS; and

3. It shall execute, at EOHHS's direction, a Trading Partner Agreement and any other agreements EOHHS determines are necessary to comply with HIPAA requirements.

E. Research Data

The Contractor shall seek and obtain EOHHS prior written authorization for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract. EOHHS may approve or deny such data requests at its sole discretion. To obtain EOHHS authorization to access data for an activity that is not directly related to the performance of this Contract, the Contractor shall:

1. Submit to EOHHS, at the direction of and in a form and format specified by EOHHS, an application to participate in an external study and application for release of MassHealth data, as appropriate, for prior review and approval;

2. If approved by EOHHS, enter into the appropriate data use agreement as directed by EOHHS; and

3. Submit to EOHHS, prior to publication, the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

F. Requesting Member-Level Data or Reports

If the Contractor wishes to receive member-level data or reports that may be available from EOHHS under the Contract, the Contractor may be required to submit a request to EOHHS and execute a data use agreement containing any representations and/or privacy and security requirements applicable to the data and/or report(s) that EOHHS may determine necessary or appropriate.

G. Business Associate Activities

The Contractor acknowledges and agrees that it is acting as EOHHS' Business Associate, as such term is defined under HIPAA, in providing services pursuant to **Sections 2.4.B, 2.4.C, 2.5, 2.6.D.2, 2.7.H, 2.7.I, 2.7.K, 2.10, 2.11, 2.14.I, 2.19, and 2.13** (to the extent that **Section 2.13** activities involve functions performed by the Contractor on EOHHS' behalf) and such additional Sections of the Contract as EOHHS shall identify in the Contract or shall identify in either written amendments to the Contract or written work

plans or instructions during the course of the Contract (such services, "Business Associate Activities").

With respect to these Business Associate Activities, the Contractor agrees to protect information received in connection with its provision of these services under this Contract, including PI, pursuant to applicable federal and state laws, EOHHS agreements, and policies, including, but not limited to, M.G.L. c. 66A, 801 CMR 3.00, M.G.L. c. 93H, 201 CMR 17, the HIPAA Rules (inclusive of 45 CFR §§ 160, 162, and 164), 42 CFR Part 431, Subpart F, 42 CFR Part 2, 45 CFR §155.260 as further described in the Data Management and Confidentiality Agreement (DMCA), attached hereto in **Appendix K** and incorporated herein.

For the avoidance of doubt, the Contractor's obligations with respect to the Business Associate Activities are in addition to those outlined in this **Section 5.2**, which stem from its status as a Covered Entity under HIPAA.

H. EOHHS reserves the right to add any requirement during the course of the Contract that it reasonably determines it must include in the Contract in order for EOHHS to comply with any applicable state or federal law or regulation, or any contractual obligation to which EOHHS is subject, relating to privacy and/or security, including but not limited to the Privacy and Security Rules, and the Contractor shall promptly execute and comply with any amendment to the Contract that EOHHS deems necessary or appropriate in connection therewith.

I. Security Controls Compliance and Audit Tasks

1. As of the effective date of the contract, the Contractor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PI, and that prevent use or disclosure of such PI, other than as provided for by this Agreement. Such safeguards shall be consistent with state and federal laws applicable to the privacy and security of personal and other confidential information, related requirements, including a HIPAA, MGL 66A (FIPA), 42 CFR 431, Subpart F, 42 CFR Part 2 ("Standards").

    a. In the event the Contractor is unable to fully comply with the Standards on the effective date, Contractor must submit to EOHHS a gap analysis detailing with which parts of the Standards the Contractor is unable to comply and a Plan of Actions and Milestones ("POAM"), providing an overview of the reasonable effort and time required to comply with the Standards.

        1) The gap analysis should identify, at a high-level:

            a) which of the Standards' controls Contractor believes they do not comply with; and

b) how the Contractor is non-compliant.

2) The POAM must, at a minimum, describe:

a) which of the Standards' controls Contractor believes they do not comply with;

b) how the Contractor is non-compliant;

c) why the Contractor believes they are non-compliant;

d) a ranking of the severity of each gap to Contractor's ability to protect the confidentiality, integrity, or availability per the rating scheme outlined in the Standards; and

e) a status as of the date of submission of the POAM of remediation efforts for the gaps and/or an explanation of compensating controls or workarounds for the gap that in the Contractor's opinion lessen or eliminate the severity of the gap.

3) EOHHS may review the gap analysis and POAM with the Contractor and will provide a timeline for implementation of the Standards and/or correction of any deficiencies that are in EOHHS' opinion material that is mutually acceptable to the parties ("Implementation Timeline"). The POAM will be updated to include the agreed-upon Implementation Timeline. EOHHS may meet with Contractor from time to time and/or as deadlines to correct deficiencies approach and/or come due and review the POAM, Implementation Timeline, and any other documentation requested by EOHHS with Contractor to determine Contractor's compliance with such documents and assess what further actions need to be taken.

b. On an annual basis, Contractor must internally review their compliance with the Standards and submit an updated POAM to EOHHS pursuant to the process outlined in **Section 5.2.I.1.A**.

c. Contractor understands that it is solely responsible for meeting the Standards and for managing its information security program. EOHHS's review of the gap analysis and/or POAM, or any other discussions of or related to the gap analysis and/or POAM, shall not constitute approval by EOHHS of their contents and will not otherwise operate to indemnify, remove liability, or otherwise absolve Contractor of any responsibility for non-compliance with the Standards.

d. In the event Contractor is unable to fully comply with the Standards by the Effective Date, Contractor shall prioritize (in no particular order) implementation of Standards controls dealing with computer access authentication, data encryption, mobile device encryption, physical access controls, appropriate employee training, and information flow identification and enforcement.

e. If Contractor hosts any Commonwealth Data or other data on behalf of EOHHS ("Hosted Data"), in addition to the foregoing security requirements, as of the Effective Date, Contractor must either be capable of providing or have subcontracted with a hosting company to provide a server environment has received a FEDRAMP Authorization to Operate at the Moderate level (the "Hosting Standards"). Contractor must ensure that all Hosted Data is located within the continental United States. Additionally, Contractor must ensure that it and/or EOHHS have at least logical control over Hosted Data.

2. Once every three years, starting on the third year after the Effective Date, and at no additional cost to EOHHS, Contractor shall engage an independent third-party auditor to conduct an audit of Contractor's compliance with the Standards and Hosting Standards. Such audit shall include, but not be limited to, an audit of the Contractor's facilities where work is performed on behalf of EOHHS and its hosting facilities where Hosted Data resides. At the conclusion of such audit, the Contractor shall provide EOHHS with the audit results and findings.

   a. At EOHHS's option and cost, EOHHS may enlist their own independent third-party auditor to conduct such audits. Contractor must permit auditor access to its facilities and must cooperate with the auditor to ensure successful completion of the audit.

   b. In the event the results of the third-party audit demonstrate that Contractor does not fully comply with the Standards or the Hosting Standards, Contractor must submit an updated POAM pursuant to the process outlined in **Section 5.2.I.1.A** that includes and addresses such deficiencies.

3. On at least an annual basis and at no additional cost to EOHHS, Contractor shall conduct a vulnerability assessment of Contractor's computing and hosting environments with respect to the services provided under this Contract. Such vulnerability assessment shall include a penetration test, using industry-standard methodology, of Contractor's computing environment. Contractor must provide EOHHS the findings of the vulnerability assessment and penetration test. If the findings demonstrate security vulnerabilities in Contractor's computing environment, Contractor must submit an updated POAM pursuant to the process outlined in **Section 5.2.I.1.A** that addresses such deficiencies.

4. Notwithstanding the foregoing, nothing contained in this **Section 5.2.I** shall abrogate or restrict EOHHS' ability to audit and inspect Contractor's facility, hosting facility or books and records, including but not limited to Contractor's Information Security Plan, business continuity plan, disaster recovery plan, or other documentation required to be maintained pursuant to the Standards and Hosting Standards or otherwise in this Contract. Such audit and/or inspection shall be conducted with reasonable notice and during Contractor's standard business hours.

5. In the event EOHHS is assessed any fine, penalty, or monetary damages as a result of a finding or judgment based in whole or in part on Contractor's non-compliance with the Standards, inability to meet any part of the Implementation Timeline, inability to abide by the POAM, or any misstatements or omissions in the POAM (collectively "Liabilities"), Contractor will indemnify EOHHS for any such Liabilities and EOHHS will be entitled to reimbursement from the Contractor for any such Liabilities. If, in EOHHS' determination, Contractor demonstrates an inability to meet any part of the Implementation Timeline, inability to abide by the POAM, or any misstatements or omissions in the POAM (including material divergence between the POAM representations and the finding of an independent third party audit), EOHHS may pursue remedies specified elsewhere in this Contract including, but not limited to, seeking monetary damages and/or terminating the Contract in whole or in part.

J. Security Controls Compliance and Audit Deliverables

The Contractor shall deliver to the Commonwealth the following Deliverables subject to acceptance or rejection by EOHHS as described in the Agreement:

1. Gap analysis including at a minimum the following:

   a. A list of gaps (if any)

   b. The cause of those gaps

2. POAM including at a minimum the following:

   a. A list of gaps (if any)

   b. The cause of those gaps

   c. Why the Contractor believes those gaps exist

   d. A raking of the gap severity

   e. An ongoing and cumulative set of status updates for remediation and/or implementation of a compensating control or workaround

3. Information Security Standards including, at a minimum, the Contractor's information security standards generally applicable to the organization.

4. FEDRAMP ATO Documentation including at a minimum a demonstration that the hosting environment has a FEDRAMP Moderate ATO.

5. Third Party Audit Reports including at a minimum all reports generated for the Contractor that will demonstrate a generally effective control environment for the work performed for EOHHS.

Section 5.3 General Terms and Conditions

A. Compliance with Laws

1. The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply, to the extent applicable, with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the Assisted Suicide Funding Restriction Act of 1997; Titles XIX and XXI of the Social Security Act and waivers thereof; Chapter 141 of the Acts of 2000 and applicable regulations; Chapter 58 of the Acts of 2006 and applicable regulations; 42 CFR Part 438; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations; and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, including but not limited to Section 1557 of such Act, to the extent such provisions apply and other laws regarding privacy and confidentiality, and as applicable, the Clean Air Act, Federal Water Pollution Control Act, and the Byrd Anti-Lobbying Amendment, and, as applicable, the CMS Interoperability and Patient Access Final Rule (CMS 9115-F).

2. In accordance with 130 CMR 450.123(B), the Contractor shall review its administrative and other practices, including the administrative and other practices of any contracted Behavioral Health organization, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance and submit a certification to EOHHS in accordance with 130 CMR 450.123(B)(1)-(3) and any additional instructions provided by EOHHS.

3. The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with any requirement of federal law or regulation.

B. Loss of Licensure/Accreditation

The Contractor shall report to EOHHS if at any time during the Contract the Contractor or any of its providers or material subcontractor loses, or is at risk of losing, any applicable license, state approval or accreditation. Such loss may be grounds for termination of the Contract under the provisions of **Section 5.5**.

C. Indemnification

The Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with the Contractor's violation of any federal or state law or regulation or any negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, provided that:

1. The Contractor is notified of any claims made directly to EOHHS within a reasonable time from when EOHHS becomes aware of the claim; and

2. The Contractor is afforded an opportunity to participate in the defense of such claims.

D. Prohibition Against Discrimination

1. In accordance with 42 U.S.C. § 1396u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any Network Provider who is acting within the scope of the Network Provider's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reasons for its decision. This Section shall not be construed to prohibit the Contractor from including Network Providers only to the extent necessary to meet the needs of Covered Individuals or from using different reimbursement for different Network Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

2. In accordance with 42 U.S.C. § 1396u-2 and 42 CFR 438.3(d), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating against a Member eligible to enroll in the Contractor's MassHealth plan on the basis of health status, need for health care, race, color, national origin, sex, sexual orientation, gender identity, or disability.

3. If a complaint or claim against the Contractor is presented to the MCAD, the Contractor shall cooperate with MCAD in the investigation and disposition of such complaint or claim.

E. Information Sharing

During the course of a Covered Individual's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable federal and state laws, the Contractor shall arrange for the transfer, at no cost to EOHHS or the Covered Individual, of medical information regarding such Covered Individual to any subsequent provider of medical services to such Covered Individual, as may be requested by the Covered Individual or such provider or be directed by EOHHS, the Covered Individual, regulatory agencies of the Commonwealth, or the United States Government. With respect to Covered Individuals who are children in the care or custody of the Commonwealth, the Contractor shall provide, upon reasonable request of the state agency with custody of the Covered Individual, a copy of said Enrollee's medical records and any care management documentation in a timely manner.

F. Other Contracts

Upon EOHHS request, the Contractor shall provide a complete list of any managed Behavioral Health care contracts it or its corporate parent or subsidiary holds within Massachusetts in addition to this Contract. EOHHS shall not disclose non-public information that the Contractor may consider proprietary, except as required by law.

Nothing contained in this Contract shall 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. The Contractor shall also provide EOHHS with a complete list of such plans and services, upon request. EOHHS shall not disclose any non-public information which the Contractor may consider proprietary, except as required by law. Nothing in this Contract shall be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other provider.

G. Title and Intellectual Property Rights

1. Definition of Property

The term "Property" as used herein includes the following forms of property: (1) confidential, proprietary, and trade secret information; (2) trademarks, trade names, discoveries, inventions processes, methods and improvements, whether or not patentable or subject to copyright protection and whether or not reduced to tangible form or reduced to practice; and (3) works of authorship, wherein such forms of property are required by Contractor to develop, test, and install the any product to be developed that may consist of computer programs (in object and source code form), scripts, data, documentation, text, photographs, video, pictures, sound recordings, training materials, images, techniques, methods, program images, text visible on the Internet, illustrations, graphics, pages, storyboards, writings, drawings, sketches, models, samples, data, other technical or business information, reports, and other works of authorship fixed in any tangible medium.

2. Contractor Property and License

Contractor will retain all right, title and interest in and to all Property developed by it, i) for clients other than the Commonwealth, and ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual property rights created by Contractor in connection with such work (hereinafter the "Contractor Property"). EOHHS acknowledges that its possession, installation or use of Contractor Property will not transfer to it any title to such property. "Contractor Property" also includes Contractor's proprietary tools, methodologies and materials developed prior to the performance of Services and used by Contractor in the performance of its business and specifically set forth in this Contract and which do not contain, and are not derived from, EOHHS's Confidential Information, EOHHS's Property or the Commonwealth Data.

Except as expressly authorized herein, EOHHS will not copy, modify, distribute or transfer by any means, display, sublicense, rent, reverse engineer, decompile or disassemble Contractor Property.

Contractor grants to EOHHS, a fully-paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to the Contractor Property to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit, copy, sublicense to any EOHHS subcontractor for purposes of creating, implementing, maintaining or enhancing a Deliverable, and create derivative works based upon Contractor Property, in any media now known or hereafter known, only to the extent the Contractor Property is embodied in the Deliverables, or otherwise required to exploit the Deliverables. During the Term of this Agreement and immediately upon any expiration or termination thereof for any reason, Contractor will provide to EOHHS the most current copies of any Contractor Property to which EOHHS has rights pursuant to the foregoing, including any related documentation.

Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS's use of Contractor Property under the license created herein, Contractor shall have all the rights and incidents of ownership with respect to Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties. Contractor shall not encumber or otherwise transfer any rights that would preclude a free and clear license grant to the Commonwealth.

3. Commonwealth Property

In conformance with the Commonwealth Terms and Conditions, all Deliverables created under this Agreement whether made by Contractor, subcontractor or both are the property of EOHHS, except for the Contractor Property embodied in the Deliverable. Contractor irrevocably and unconditionally sells, transfers and assigns to EOHHS or its designee(s), the entire right, title, and interest in and to

all intellectual property rights that it may now or hereafter possess in said Deliverables, except for the Contractor Property embodied in the Deliverables, and all derivative works thereof. This sale, transfer and assignment shall be effective immediately upon creation of each Deliverable and shall include all copyright, patent, trade secret, trademark and other intellectual property rights created by Contractor or subcontractor in connection with such work (hereinafter the "Commonwealth Property"). "Commonwealth Property" shall also include the specifications, instructions, designs, information, and/or materials, proprietary tools and methodologies including, but not limited to software and hardware, owned, licensed or leased by EOHHS and which is provided by EOHHS to Contractor or of which Contractor otherwise becomes aware as well as EOHHS's Confidential Information, the Commonwealth Data and EOHHS's intellectual property and other information relating to its internal operations.

All material contained within a Deliverable and created under this Agreement, except for the Contractor Property embodied in a Deliverable (for which the Contractor shall grant EOHHS the license described in **Section 5.3.G.2**), are works made for hire.

Contractor agrees to execute all documents and take all actions that may be reasonably requested by EOHHS to evidence the transfer of ownership of or license to intellectual property rights described in this **Section 5.3.G**, including providing any code used exclusively to develop such Deliverables for EOHHS and the documentation for such code. The Commonwealth retains all right, title and interest in and to all derivative works of Commonwealth Property.

EOHHS hereby grants to Contractor a nonexclusive, revocable license to use, copy, modify and prepare derivative works of Commonwealth Property only during the term and only for the purpose of performing services and developing Deliverables for the EOHHS under this Agreement.

Contractor agrees that it will not: (a) permit any third party to use Commonwealth Property; (b) sell, rent, license or otherwise use the Commonwealth Property for any purpose other than as expressly authorized under this Agreement; or (c) allow or cause any information accessed or made available through use of the Commonwealth Property to be published, redistributed or retransmitted or used for any purpose other than as expressly authorized under this Agreement. Contractor agrees not to, modify the Commonwealth Property in any way, enhance or otherwise create derivative works based upon the Commonwealth Property or reverse engineer, decompile or otherwise attempt to secure the source code for all or any part of the Commonwealth Property, without EOHHS's express prior consent. EOHHS reserves the right to modify or eliminate any portion of the Commonwealth Property in any way at any time. EOHHS may terminate use of the Commonwealth Property by Contractor immediately and without prior notice in the event of the failure of such person to comply with the

security or confidentiality obligations hereunder. The Commonwealth Property is provided "AS IS" and EOHHS FOR ITSELF, ITS AGENCIES AND ANY RELEVANT AUTHORIZED USERS EXPRESSLY DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES CONCERNING THE COMMONWEATH PROPERTY, COMMONWEALTH DATA OR ANY THIRD PARTY CONTENT TO BE PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, OR STATUTORY, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF NONINFRINGEMENT, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR QUALITY OF SERVICES.

H. Ownership of Furnishings and Equipment

Unless t, the Contractor shall provide and retain all furnishings and equipment used in the completion of its performance under this Contract.

I. Counterparts

The 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.

J. Entire Contract

The 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 the Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein. This Contract, including the Commonwealth of Massachusetts Standard Contract Form and Commonwealth Terms and Conditions, shall supersede any conflicting verbal or written agreements, forms, or other documents relating to the performance of this Contract.

K. No Third Party Enforcement

No person not executing this Contract shall be entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

L. Intermediate Sanctions

1. In addition to termination under **Section 5.5**, EOHHS may, in its reasonable discretion, impose any or all of the sanctions in **Section 5.3.L.2** below, for any of the following circumstances. EOHHS shall only impose those sanctions it determines to be reasonable and appropriate for the specific violation(s) identified. Sanctions may be imposed if the Contractor:

a. Fails substantially to provide Medically Necessary items and services required to be provided under this Contract or under law to Covered Individuals and Uninsured Individuals including persons covered by Medicare only;

b. Imposes co-payments, premiums or other charges on Covered Individuals and Uninsured Individuals including persons covered by Medicare in excess of any permitted under this Contract;

c. Discriminates against Covered Individuals on the basis of race, color, gender, or national origin;

d. Discriminates among Covered Individuals on the basis of health status or need for health care services, including termination of enrollment or refusal to reenroll a Covered Individual, except as permitted under **Section 2.4.B**, or any practice that would reasonably be expected to discourage enrollment by Covered Individuals whose medical condition or history indicates probable need for substantial future medical services;

e. Misrepresents or falsifies information provided to CMS or EOHHS;

f. Misrepresents or falsifies information provided to Covered Individuals, Members, Providers, or PCCs;

g. Fails to comply with requirements regarding physician incentive plans;

h. Fails to comply with requirements regarding Provider-Covered Individual communications;

i. Fails to comply with federal or state statutory or regulatory requirements related to the Contract;

j. Violates restrictions or other requirements regarding marketing;

k. Fails to comply with health improvement targets and quality improvement goal requirements set forth in **Section 2.13** of this contract;

l. Fails to comply with any corrective action plan required by EOHHS;

m. Fails to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under **Section 2.2.B** and **Appendix B-1** of this Contract

n. Fails to meet deliverable timelines which deliverables shall include those reports, analyses, workplans, surveys, evaluations, metrics and other documents with submission dates explicitly defined in the Contract or, if a date is not specified, with explicit timelines or bases of specified duration provided therein;

o. Submits required reports that are either late or missing a significant amount of information or data;

p. Fails to meet any of the standards for data submission described in this contract, including accuracy, completeness, timeliness, and other standards for Encounter Data described in **Section 2.14.E** and **Appendices D-1** and **D-2**. Sanctions for such failure are further described in **Section 5.3.L.2**;

q. Fails to meet satisfactory performance based upon EOHHS' Performance Management Evaluation, in accordance with the provisions of **Section 3.1.C**;

r. Fails to comply with financial solvency requirements as set forth in **Section 2.15**;

s. Fails to comply, as determined by EOHHS from audit findings, with any provision of this Contract related to DSRAs;

t. Fails to comply with the False Claims provision of the Deficit Reduction Act of 2005

u. Fails to take all steps necessary, as determined by EOHHS, to enable EOHHS to maximize rebate collection as set forth in **Section 2.6.D.1.d**;

v. Fails to comply with any other requirement of Section 1932 of the Social Security Act, and any implementing regulations; or

w. Fails to comply with any other requirements of this Contract.

2. Such sanctions may include without limitation, any or all of the following:

a. Civil monetary penalties in accordance with 42 CFR 438.704;

b. financial penalties, including without limitation asserting EOHHS's rights under its Performance Guarantee, in accordance with the provisions of **Appendix H-2**;

c. withholding of administrative payments;

d. withholding Performance Incentive bonuses;

e. 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) and 42 CFR 438.706;

f. suspension of payment to the Contractor; adjusting or withholding Estimated Base Capitation Rate Payments or other Base PMPM Capitation Rate payments;

g. adjusting or withholding of Service Compensation Payments;

h. adjusting or withholding the DMH Administrative Compensation Rate or Administrative Component of the MassHealth Capitation Payments; and

3. withholding gain from any risk-sharing arrangement.

4. For any Contract responsibilities for which the Contractor utilizes a Material Subcontractor, if EOHHS identifies any deficiency in the Contractor's performance under the Contract for which the Contractor has not successfully implemented an approved corrective action plan in accordance with **Section 5.3.M**, EOHHS may:

a. require the Contractor to terminate its agreement with the Material Subcontractor and subcontract with a Material Subcontractor deemed satisfactory by EOHHS; or

b. otherwise require the Contractor to altern the manner or method in which the Contractor performs such Contractor responsibility.

5. Civil monetary penalties shall be administered in accordance with 42 CFR 438.704 as follows:

a. The limit is $25,000 for each determination under the following:

1) failure to provide Medically Necessary items and services;

2) misrepresentation or false statement to a Covered Individual, Member, or Provider;

3) failure to comply with requirements regarding physician incentive plans; or

4) violates restrictions or other requirements regarding Marketing.

b. The limit is $100,000 for each determination under the following:

1) discrimination; or

2) misrepresentation or false statements to CMS or EOHHS.

c. The limit is $15,000 for each Covered Individual EOHHS determines was terminated or not re-enrolled because of a discriminatory practice under **Section 5.3.L.1.d** above (with an overall limit of $100,000 under **Section 5.3.L.4.b** above).

d. The limit is $25,000 or double the amount of the excess charges, whichever is greater, for each determination under **Section 5.3.L.1.b** above.

6. Encounter Data and other Related Data Capitation Payment Deduction

a. For each month where the Contractor has not met data submission standards, including those for Encounter Data, as described in **Section 2.14, Appendix E,** and elsewhere in this Contract, EOHHS shall apply a Capitation Payment deduction as follows:

1) EOHHS shall deduct 2% from the Contractor's Capitation Payment for one month;

2) Once Contractor has corrected a month's data submission, in EOHHS's reasonable determination, EOHHS shall pay the Contractor the amount of the deduction applied for such month;

3) If EOHHS subsequently detects additional deficiencies in such corrected data submission, EOHHS may apply the deduction again to a subsequent month's Capitation Payment;

4) EOHHS shall administer such deductions so that EOHHS shall at no time have applied more than five such deductions. Deductions that are paid back as described in **Section 5.3.L.5.a** above shall not count towards such five deduction limit; and

5) Notwithstanding the deductions described in this Section, EOHHS may take corrective action for any failure by Contractor to comply with the data submission requirements of this Contract;

b. If the Contractor does not meet Encounter Data and other data or documentation submission deadlines for risk sharing arrangements as specified in **Section 4.6,** EOHHS may apply a Capitation Payment deduction equal to $400,000.00, if EOHHS chooses to incorporate such Encounter Data and other data and documentation into the risk sharing arrangement calculations set forth in **Section 4.6** for that particular Contract Year. EOHHS will not impose such Capitation Payment deduction if EOHHS chooses not to incorporate such Encounter Data and other data and documentation into such risk sharing arrangement calculations for that particular Contract Year pursuant to **Section 4.6**.

7. For each instance where the Contractor has failed to submit on time its Financial Encounter Validation Report as set forth in **Appendix E-4**, EOHHS may apply a Capitation Payment deduction as follows:

a. EOHHS may deduct $500.00 for each business day the Financial Encounter Validation Report is late from the Contractor's next Capitation Payment, unless:

1) the Contractor has requested an extension at least three business days prior to the report's due date, including with its request the

reason for the needed extension and an action plan and timeline for when the Contractor is able to submit such report; and

2) EOHHS has granted the Contractor's request

b. If EOHHS grants the Contractor's extension request, EOHHS may deduct $500.00 for each business day the Contractor's Financial Encounter Validation report is late past the new deadline EOHHS granted under the Contractor's extension request from the Contractor's next Capitation Payment.

8. The intermediate sanctions provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

9. Denial of Payment Sanction

In accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e), EOHHS shall deny payments under this Contract to the Contractor for New Covered Individuals if CMS denies payment to EOHHS for the same New Covered Individuals in the following situations:

a. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.3.L.1.** of this Contract is affirmed on review pursuant to 42 CFR 438.730(d).

b. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.3.L.1.** of this Contract is not timely contested by the Contractor under 42 CFR 438.730(c).

For the purposes of this **Section 5.3.L.9,** New Covered Individual shall be defined as a Covered Individual that applies for enrollment after the Effective Date of this Sanction (the date determined in accordance with 42 CFR 438.730(f)).

c. Before imposing any of the intermediate sanctions specified in this **Section 5.3.L**, EOHHS shall give the Contractor written notice that explains the basis and nature of the sanctions not less than 14 calendar days before imposing such sanction.

M. Corrective Action Plan

If, at any time, EOHHS determines that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan to correct such deficiency. EOHHS shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall, upon EOHHS approval, immediately implement the corrective action plan, as approved or modified by EOHHS. The Contractor's failure to implement any corrective action plan may, in the sole discretion of EOHHS, be considered breach of

Contract and subject to any and all contractual remedies including: those under the Contractor's Performance Guarantees in accordance with **Appendix H-2**; termination of the Contract with or without notice; or other intermediate sanctions as described in **Section 5.3.L**.

N. Section Headings

The headings of the Sections of the Contract are for convenience only and do not affect the construction hereof.

O. Administrative Procedures Not Covered

EOHHS may from time-to-time issue memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters.

P. Effect of Invalidity of Clauses

If any clause or provision of the Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void; any such invalidity shall not affect the validity of the remainder of the Contract.

Q. Conflict of Interest

Neither the Contractor nor any Material Subcontractor 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, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor have any financial, legal, contractual or other business interest in any entity performing health plan enrollment functions for EOHHS, the CSC Enrollment Vendor and subcontractor(s) if any).

R. Insurance for Contractor's Employees

1. The Contractor shall agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and shall provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Covered Individuals, shall obtain and maintain appropriate professional liability insurance coverage. The Contractor shall, at EOHHS's request, provide certification of professional liability insurance coverage.

2. The Contractor shall offer health insurance to its employees sufficient to ensure that it is not obligated to provide a share payment under Chapter 58.

S. Waiver

The exercise or non-exercise of any authority under this Contract by either party, including, but not limited to, EOHHS's review and approval of materials submitted in

relation to the Contract, shall not relieve the other party of any obligations set forth herein, nor be construed as a waiver of any of the other party's obligations or as acceptance by EOHHS of any unsatisfactory practices or breaches by the other party.

Section 5.4 Record Retention, Inspection and Audit

The Contractor shall make available the administrative and medical records maintained by the Contractor and its subcontractors, including but not limited to Network Providers, to EOHHS and its agents, designees or contractors, 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 and/or medical audits, programmatic review, inspections, and examinations, provided that such activities shall be conducted during the normal business hours of the Contractor. Such records shall be maintained and available to EOHHS for seven (7) years. Such administrative and medical records shall include but not be limited to care management documentation, financial statements, Provider Contracts, contracts with subcontractors, including financial provisions of such Provider Contracts and subcontractor contracts. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his designee, the Governor or his designee, and the State Auditor or his designee may inspect and audit any financial records of the Contractor or its subcontractors.

Notwithstanding the generality of the foregoing, pursuant to 42 CFR 438.3(h), EOHHS, other representatives from the Commonwealth of Massachusetts, CMS, the Office of the Inspector General, the Comptroller General, and their designees, may, at any time, inspect and audit any records or documents of the Contractor or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where activities or work related to this Contract is conducted. The right to audit under this Section exists for 10 years from the last day of this Contract or from the date of completion of any audit, whichever is later. The Contractor shall maintain all records and documents relating to activities or work under this Contract for a period of no less than 10 years.

In cases where such an audit or review results in EOHHS believing an overpayment has been made, EOHHS may seek to pursue recovery of overpayments. EOHHS will notify the Contractor in writing of the facts upon which it bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. In the event the overpayment amount is based on a determination by a federal or state agency (other than EOHHS) of an overpayment by EOHHS, EOHHS will so inform the Contractor and, in such cases, the Contractor may contest only the factual assertion that the federal or state agency made such a determination. The Contractor may not contest in any proceeding before or against EOHHS the amount or basis for such determination.

Section 5.5 Termination of Contract

A. Termination without Prior Notice

EOHHS may terminate the Contract immediately and without prior written notice, upon any of the following events. EOHHS shall provide written notice to the Contractor upon such termination:

1. The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property.

2. The Contractor's admission in writing that it is unable to pay its debts as they mature.

3. The Contractor's assignment for the benefit of creditors.

4. Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceeding.

5. Commencement of an involuntary proceeding against the Contractor or Material Subcontractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within 60 days.

6. The Contractor incurs loss of any of the following: (1) licensure at any of the Contractor's facilities; (2) state approval of the Contractor; or (3) NCQA accreditation;

7. Cessation in whole or in part of state or federal funding for this Contract, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases;

8. EOHHS determines in its reasonable discretion that the health, safety or welfare of its Covered Individuals requires immediate termination of the Contract.

9. The Contractor is non-compliant with **Section 5.1.G**, and the Secretary of Health and Human Services, in accordance with 42 CFR 438.610(c), directs EOHHS to terminate, or does not permit EOHHS to extend, renew or otherwise continue this Contract.

10. The Contractor is non-compliant with **Section 5.1.O**.

B. Termination with Prior Notice

1. Either party may terminate the Contract upon breach by a party of any duty or obligation hereunder, which breach continues unremedied for 30 days after written notice thereof by the other party.

2. EOHHS may terminate the Contract after written notice thereof to the Contractor in the event the Contractor fails to accept EOHHS's proposed offer of payment for any financial provision identified in **Section 4** of this Contract.

3. EOHHS may terminate the Contract if the EOHHS determines that state or federal health care reform initiatives or state or federal health care cost containment initiative makes termination of the Contract necessary or advisable as determined by EOHHS

C. Continued Obligations of the Parties

1. In the event of termination, expiration or non-renewal of the Contract, the obligations of the parties hereunder with regard to each Covered Individual at the time of termination, expiration, or non-renewal shall continue until the Covered Individual has been disenrolled; provided, however, that EOHHS shall exercise best efforts to promptly complete all disenrollment activities within six months from the date of termination, expiration or non-renewal.

2. In the event that the Contract is terminated, expires, or is not renewed for any reason:

   a. EOHHS shall be responsible for notifying all Covered Individuals covered by this Contract of the date of termination and the process by which they will continue to receive medical care;

   b. The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for coverage of Covered Individuals for periods after the effective date of their disenrollment; and

   c. The Contractor shall supply to EOHHS all information necessary for the reimbursement of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims shall be paid to the Contractor accordingly.

3. For termination of the Contract for failure by the Contractor to agree to any Capitation Rate, the Contractor shall accept the lesser of the most recently agreed to Capitation Rates or the new Capitation Rate for each RC as payment in full for BH Covered Services and all other services required under this Contract delivered to Covered Individuals until all Covered Individuals have been disenrolled from the Contractor's Plan; and

4. For expiration or non-renewal of the Contract following a reprocurement of the PCC Plan's BH Program, the financial terms in effect for the current Contract Year shall remain in effect until all Covered Individuals have been disenrolled, except that there shall be no Performance Incentives in EOHHS's sole discretion.

D. Termination Authority

The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

E. Termination Pursuant to 42 CFR 438.708

1. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708

2. If EOHHS terminates this Contract pursuant to its authority under 42 CFR 438.708, EOHHS shall provide the Contractor with a pre-termination hearing in accordance with 42 CFR 438.710 as follows:

    a. EOHHS shall give the Contractor written notice of intent to terminate, the reason for termination, and the time and place of the hearing;

    b. After the hearing, EOHHS shall give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

    c. If the decision is affirmed, EOHHS shall give Covered Individuals notice of the termination and information on their options for receiving MassHealth services following the effective date of termination in accordance with 42 CFR 438.710(b)(2)(iii) and **Section 5.5.C.2**. of this Contract.

3. If EOHHS terminates this Contract, EOHHS and the Contractor shall comply with all Continuing Obligations set forth in **Section 5.5.C** of this Contract;

Section 5.6 Contract Term

The Contract is effective upon execution, through December 31, 2027, unless otherwise terminated or extended in accordance with this Section or at such other time that EOHHS may implement changes that render the performance of the Contract unnecessary. At EOHHS's option, the Contract may be extended in any increments through December 31, 2032, and upon terms to be negotiated by the parties. EOHHS reserves the right to further extend the Contract for any reasonable increment it determines necessary to complete a subsequent procurement. Extension of this Contract is subject to mutual agreement on terms by both parties, further legislative appropriations, continued legislative authorization, and EOHHS' determination of satisfactory performance.

Section 5.7 Additional Modifications to the Contract Scope

EOHHS shall have the option at its sole discretion to modify, reduce or terminate any activity related to the Contract whenever, in the judgment of EOHHS, the goals of the project have been modified or altered in any way that necessitates such changes. In the event of the reduction of the scope of work for any tasks or portions thereof, EOHHS will provide written notice to the Contractor. In the event of a change in the scope of work of any tasks or portions thereof, EOHHS will initiate negotiations with the Contractor.

Section 5.8 Amendments

A. 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 state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto. Further, the Contractor agrees to take such action as is necessary to amend this Contract in order for EOHHS to comply with all applicable state and federal laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Amendments of 1997 (BBA) and any regulations promulgated thereunder, the Deficit Reduction Act, and Health Care Reform, as well as any regulations, policy guidance, and policies and procedures related to any such applicable state and federal laws. EOHHS additionally reserves the right, at its sole discretion, to amend the Contract to implement judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS or the Contract. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.

B. EOHHS and Contractor mutually acknowledge that unforeseen policy, operational, methodological, or other issues may arise throughout the course of this Contract. Accordingly, EOHHS and Contractor agree to work together in good faith to address any such circumstances and resolve them, and, if necessary, will enter into amendments to this Contract on mutually agreeable terms.

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

1. new MassHealth programs;
2. expansion of or changes to existing MassHealth programs;
3. other programs as specified by EOHHS;
4. programs resulting from state or federal legislation, including but not limited to the Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law 111–148 March 23, 2010), regulations, initiatives, or judicial decisions that may affect in whole or in part any components of the PCC Plan or the BHP;
5. requiring or allowing individuals age 65 and over, with or without Medicare and individuals age 21 or over with Medicare to enroll in the PCC Plan or the BHP; and
6. changes the managed care options available to any or all MassHealth Coverage Types, in whole or in part, or excluding any or all MassHealth Coverage Types from either mandatory or voluntary Managed Care.

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

D. EOHHS reserves the right to enroll additional MassHealth Members over the term of the Contract, or to reduce current enrollment levels. Possible EOHHS initiatives that could change enrollment include but are not limited to:

1. Increased or decreased MassHealth membership pursuant to any MassHealth waiver;

2. Expanded eligibility coverage for children under age 19 or adults over 65;

3. Any other state or federal changes that result in an increase or decrease in MassHealth-eligible individuals, including changes to comply with the ACA, such as an adjustment to the minimum federal poverty eligibility level, or a change in the MassHealth Managed Care enrollment policy or criteria for participation; and

4. Changes in EOHHS's methodology by which assignments are made to MassHealth Managed Care plans.

E. The Contractor shall propose to EOHHS for approval during the term of the Contract new initiatives and reimbursement mechanisms designed to further integrate PCC Plan administrative functions with BH management and performance. Such proposals shall include, upon EOHHS request, detailed work plans and timelines. EOHHS may at its sole discretion accept, reject or modify any proposed initiative.

Section 5.9 Order of Precedence

The Contractor's response to EOHHS's Request for Responses (RFR) that served as the basis for this Contract is incorporated by reference into the Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

A. this Contract, including any amendments thereto;

B. EOHHS's Request for Responses (RFR) for a Vendor to Provide Comprehensive Behavioral Health Program and Management Support Services , issued on March 17, 2022, including any amendments thereto; and

C. the Contractor's response to the RFR identified below submitted on June 6, 2022.

Section 5.10 Managed Care Activities Vacated by the Court

Should any part of the scope of work under this Contract relate to an EOHHS program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. EOHHS must adjust the capitation rates for at risk services to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If EOHHS paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the EOHHS. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Section 5.11 Written Notices

Notices to the parties as to any Contract matter will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand as follows:

To EOHHS:

Chief of Behavioral Health
Executive Office of Health and Human Services
1 Ashburton Place, 11th floor
Boston, MA 02108

With copies to:

General Counsel
Executive Office of Health and Human Services
1 Ashburton Place, 11th floor
Boston, MA 02108

Rashiem Grant, Contract Manager
Executive Office of Health and Human Services
Accounting Unit, 7th floor
600 Washington Street
Boston, MA 02111-1712

And, in addition, for notices required by the provisions of **Section 5.2**, a copy to:

EOHHS Privacy Office
One Ashburton Place, 11th Floor
Boston, MA 02111

To the Contractor:

Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118
Attention: Chief Executive Officer

With copies to:

Beacon Health Options, Inc.
200 State Street, Suite 302
Boston, MA 02109
Attention: General Counsel