APPENDIX J-1

PRIMARY CARE PAYMENT REFORM INITITIATVE CONTRACT ADDENDUM

TO THE

FOURTH AMENDED AND RESTATED
PRIMARY CARE CLINICIAN PLAN PROVIDER CONTRACT

This Addendum to the Primary Care Clinician Plan Provider Contract, as amended (Contract Addendum) is by and between the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) with its principal office at 1 Ashburton Place, 11th floor, Boston MA 02108 and _____ [Contractor name in New MMIS] (Contractor) located at _____ [Contractor address from New MMIS].

WHEREAS, EOHHS is a governmental agency responsible for the Commonwealth's administration of Title XIX, Title XXI and various Demonstration and Home and Community-Based Waivers (MassHealth); and

WHEREAS, the Primary Care Payment Reform Initiative (PCPRI) is an EOHHS initiative to implement Primary Care payment reform with Primary Care Clinicians (PCCs) and promote integration of Behavioral Health Services with the provision of Primary Care; and

WHEREAS, Contractor is a PCC that has been selected for participation in the PCPRI;

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

TABLE OF CONTENTS

Unless expressly stated herein, all provisions of the Fourth Amended and Restated Primary Care Clinician Plan (PCC) Provider Contract ("PCC Contract") as may be amended from time to time continue to apply, in addition to the provisions of this Contract Addendum. To the extent that this Contract Addendum contradicts, is inconsistent or in conflict with any prior agreements between the parties, this Contract Addendum supersedes any conflicting or inconsistent provision of any prior agreement and is controlling to the extent necessary to resolve such conflict or inconsistency.

Except as otherwise provided, all requirements and payment provisions of this Contract Addendum shall apply to Contractor and its Participating Practice Sites as listed in Contractor's Response. Contractor's non-participating Practice Sites shall not be bound to comply with the requirements of and shall not be paid in accordance with this Contract Addendum.

SECTION 1. DEFINITIONS

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

Actual Spend: Average expenditures by MassHealth and the MCOs on Shared Savings Included Services for Contractor's Panel Enrollees during the performance period.

Actual Spend for PCC Panel Enrollees: The average MassHealth expenditures on Shared Savings Included Services for Contractor's PCC Panel Enrollees during the performance period.

Alternative Payment Methodologies: Methods of payment that are not solely based on Fee-For-Service reimbursements; provided that, "alternative payment methodologies" may include, but shall not be limited to, shared savings arrangements, bundled payments and global payments; provided further, that "alternative payment methodologies" may include Fee-For-Service payments, which are settled or reconciled with a bundled or global payment.

Base Rate: A payment rate set by EOHHS for each provider type (e.g., physician, community health center, or acute hospital outpatient department) and Comprehensive Primary Care Payment (CPCP) Tier, or established by contract by a Managed Care Organization, for use in the calculation of the CPCP Rate.

Behavioral Health: Health related to mental illness, emotional disorders and substance use, and the application of behavioral principles to address lifestyle and health risk issues.

Behavioral Health Covered Services: The Behavioral Health Services Contractor is responsible for providing to Panel Enrollees, as applicable, and as described in **Attachment K** of the RFA.

Behavioral Health Integration: The clinical integration and coordination of Primary Care Services and Behavioral Health Services.

Behavioral Health Option: One of three options for integrating Behavioral Health with Primary Care, as follows: (1) Non-Co-Located but Coordinated; (2) Co-Located; and (3) Clinically Integrated.

Behavioral Health Provider: A Master's or doctoral level, licensed professional, or a trainee from an approved program operating under the supervision of an appropriate licensed professional, that provides Behavioral Health Services.

Behavioral Health Services: Health care services related to mental illness, emotional disorders and substance use, and the application of behavioral principles to address lifestyle and health risk issues.

Care Coordination: A set of services focused on tracking and assisting patients as they move across care settings and coordinating services with other service providers, including Behavioral Health Services, specialty care, inpatient care, social services, natural community supports and long-term care providers.

Certification: The certification form attached to the RFA as **Attachment F**, as completed and submitted by Contractor in its Response to the RFA.

Clinical Care Management: A set of services focused on intensive monitoring, follow-up, Care Coordination, and other clinical management for Highest Risk Panel Enrollees.

Clinical Care Manager: A licensed, clinical professional and member of the Multidisciplinary Care Team who is responsible for the coordination and provision of Clinical Care Management services.

Comprehensive Primary Care Payment (CPCP): A risk adjusted, per Panel Enrollee, per month payment for a defined set of Primary Care Services and Behavioral Health Services.

Contract Addendum to PCC Plan Provider Contract ("Contract Addendum" or "Addendum"): This addendum to the PCC Plan Provider Contract executed between Participant and EOHHS pursuant to this RFA, and any amendments thereto. The Contract Addendum incorporates by reference all attachments and appendices thereto, including Participant's Response to the RFA.

Contractor: The PCC that has signed this contract and that has been selected for participation in the PCPRI.

Contractor's Behavioral Health Provider: A Behavioral Health Provider providing CPCP Covered Services to Panel Enrollees enrolled with Contractor as part of the PCPRI.

CPCP Covered Services: The set of services, listed in **Attachment C** of the RFA (List of CPCP Services) and **Attachment K** of the RFA (List of Behavioral Health Services) as applicable, that Contractor is responsible for providing to Panel Enrollees, and that is paid for by the Comprehensive Primary Care Payment.

CPCP Rate: The rate paid by EOHHS to Contractor for provision of the CPCP Covered Services.

CPCP Tier: One of three options for the CPCP, each of which includes a different set of Behavioral Health Services.

CPCP Tier 1: No separately billable Behavioral Health Covered Services.

CPCP Tier 2: Minimum set of Behavioral Health Covered Services (**Exhibit K-1** of RFA).

CPCP Tier 3: Maximum set of Behavioral Health Covered Services (**Exhibit K-2** of RFA).

Downside Risk: The financial risk taken on by Contractor in Track 1 (Upside / Downside Risk) or Track 2 (Transitioning to Downside Risk), for which Contractor is required to pay EOHHS the amount of any Shared Losses.

Effective Date: The latest date that this Contract Addendum has been executed by an authorized signatory of the Contractor and EOHHS.

Electronic Medical Record (EMR): A systematic collection of electronic health information about individual patients or populations that is capable of being shared across different health care settings.

Emergency Services Programs: The Massachusetts-sponsored care system that delivers crisis Behavioral Health Services across the Commonwealth.

Executive Office of Health and Human Services (EOHHS): The single state agency responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Title XIX and XXI of the Social Security Act and other applicable laws and waivers.

Expected External Service Provision Adjustment: A factor determined by EOHHS for use in calculating the CPCP, to reflect Panel Enrollees' receipt of CPCP Covered Services from health care providers other than Contractor or certain Pooled Participants pursuant to **Section 4.1.A.4.b.** of this Contract Addendum.

Fee-for-Service: A payment mechanism in which all reimbursable health care activity is described and categorized into discrete and separate units of service and each health care provider is separately reimbursed for each discrete service rendered to a patient.

Highest Risk Panel Enrollee: A Panel Enrollee with one or more chronic conditions who EOHHS or Contractor determines would benefit from the provision of Clinical Care Management services which would reasonably be expected to result in improved health status and decreased health care expenditures through avoidable high cost or high intensity services, such as inpatient services or emergency department services.

Integrated Care Plan: An individualized patient care plan developed for a Highest Risk Panel Enrollee that integrates medical and Behavioral Health Services and includes the Panel Enrollee/family/caregiver's self-identified strengths and goals and may include natural community supports and other community resources.

Learning Collaborative: A shared learning, educational process which may include attending in-person learning sessions, sharing best practices, participating in conference calls and webinars, working with medical home facilitators, monitoring progress on achieving stated aims,

and implementing quality improvement cycles designed to develop changed and improved delivery of care and practice site processes consistent with the PCMH core competencies.

Long Term Services and Supports (LTSS): The services listed on **Attachment J** of the RFA.

Managed Care Organization (MCO): A managed care organization, as defined in 42 C.F.R. 438.2, that contracts with MassHealth; provided, however, that Managed Care Organization shall not include a Senior Care Organization or an Integrated Care Organization.

Massachusetts Health Information Highway (Mass HIway): The state-wide health information exchange in Massachusetts, administered by EOHHS, which enables the electronic movement of health related information among diverse organizations, such as doctors' offices, hospitals, laboratories, pharmacies, skilled nursing facilities and health plans.

MassHealth: The medical assistance or benefit programs administered by EOHHS to provide and pay for medical services to eligible Members pursuant to Title XIX of the Social Security Act, Title XXI of the Social Security Act, M.G.L. c. 118E, and other applicable laws and waivers.

Material Subcontractor: Any entity from which 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 or payment of Behavioral Health Covered Services or CPCP Covered Services including, but not limited to, behavioral health, claims processing, Clinical Care Management, utilization management or pharmacy benefits, including specialty pharmacy providers.

Meaningful Use: The set of standards defined by the Centers for Medicare & Medicaid Services that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria.

Medical Home Load: The portion of the CPCP Base Rate that provides compensation for transformation costs associated with non-billable services, as described in Section 4.1.A.2.a of this Contract Addendum.

Multidisciplinary Care Team: A Primary Care Clinician-based team assigned to manage care for a Panel Enrollee for which the composition of team members is determined by the needs of the Panel Enrollee.

Integrated Care Organizations: A health plan or provider-based organization contracted to provide and accountable for providing integrated care to individuals aged 21 up to 64 at the time of enrollment, who are simultaneously qualified for MassHealth Standard or CommonHealth and Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. and who do not have any other comprehensive public or private health care coverage (also known as the One Care plan).

Operational Start Date: March 1, 2014, or another date specified by EOHHS.

Panel: All Members enrolled (i) in the PCC Plan or (ii) with a MCO that has entered into a contract amendment with the Participant pursuant to **Section 2.5** of the RFA, who are assigned to a particular PCC.

Panel Enrollee: A Member enrolled (i) in the PCC Plan or (ii) with a MCO that has entered into a contract amendment with the Participant pursuant to **Section 2.5** of the RFA, that is assigned to the Panel of Contractor; provided, however, that a Panel Enrollee does not include Members enrolled with an Integrated Care Organization or who have third party insurance.

Participant: A Primary Care Clinician that has been selected by and contracts with EOHHS to participate in the PCPRI.

Participating Practice Site: A physical location with an individual address from which Contractor provides the Primary Care Services required by the RFA and this Contract Addendum.

Patient-Centered Medical Home (PCMH): A model of care delivery in which a Primary Care Clinician and members of his or her care team coordinate all of a patient's health needs, including management of chronic conditions, visits to specialists, hospital admissions, and reminding patients when they need check-ups and tests.

Patient-Centered Medical Home Initiative (PCMHI): The three-year demonstration initiative established in 2010 and administered by EOHHS in which each Primary Care Clinician selected for the program receives payments through Alternative Payment Methodologies and/or technical assistance to transform its practice into a Patient-Centered Medical Home.

Patient Registry: An electronic system for tracking information that EOHHS has determined is critical to the management of the health of a Panel, including dates of delivered and needed services, laboratory values needed to track a chronic condition, and other measures of health status.

Pay-for-Quality (P4Q) Total Performance Score: A score calculated by EOHHS based on Contractor's performance on Quality Measures to be used for Quality Incentive Payments.

Pay-for-Reporting (P4R) Total Performance Score: A score calculated by EOHHS based on Contractor's reporting of Quality Measures to be used for Quality Incentive Payments.

PCC Contract: The Fourth Amended and Restated PCC Plan Provider Contract between PCC Plan providers and EOHHS.

PCC Panel Enrollee: A Member enrolled in the PCC Plan that is assigned to the Panel of Contractor; provided, however, that a Panel Enrollee does not include Members enrolled with a One Care plan or who have third party insurance.

Peer: A person, such as a family member, with lived experience with a particular condition or set of conditions, such as mental health, substance use, or physical illnesses, who can serve as a supportive advocate for the Panel Enrollee.

Pooled Participants: Participants that aggregate the number of Panel Enrollees in each Participant's Panel or that are aggregated by EOHHS in the manner, to the extent and for the purposes permitted by the RFA.

Practice Site: A physical location with an individual address from which Contractor provides Primary Care Services.

Primary Care or Primary Care Services: Health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician / gynecologist, pediatrician, independent nurse practitioner, to the extent the furnishing of those services is legally authorized in the Commonwealth. Primary Care Services include CPCP Covered Services as listed in Attachment C of the RFA. Primary Care Services do not include emergency or post-stabilization services provided in a hospital or other outpatient setting.

Primary Care Clinician (PCC): A physician, independent nurse practitioner, group practice organization, community health center, hospital-licensed health center, or acute hospital outpatient department, with a signed PCC Plan Provider agreement that is approved by EOHHS, pursuant to 130 CMR 450.118.

Primary Care Clinician (PCC) Plan's Behavioral Health Vendor (BH Vendor): The entity with which EOHHS contracts to administer EOHHS's Behavioral Health program for Members enrolled in the PCC Plan.

Primary Care Payment Reform Initiative (PCPRI): The program that is the subject of this Contract Addendum.

Primary Care Provider: A health care professional licensed and qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes or otherwise provides or proposes health care services, initiates referrals for specialist care and maintains continuity of care within the scope of practice. A Primary Care Provider may be, but is not necessarily, a PCC in the PCC Plan.

Quality Incentive Payment: A type of payment made to Contractor if it has met certain Quality Measures, as further described in **Section 5.3** of the RFA and **Sections 4.2.B** and **3.2** of this Contract Addendum.

Quality Measures: A set of metrics defined by EOHHS to assess the quality and care furnished to a Panel Enrollee, as listed in **Attachment A** to this Contract Addendum.

Request for Applications (RFA): The Request for Applications for the Primary Care Payment Reform Initiative issued by EOHHS on March 7, 2013, and as subsequently amended, and all of its Attachments.

Response: Contractor's submission in response to the RFA to participate in the PCPRI, including, but not limited to, the Application, Transformation Plan, Certification Statement and any supporting documentation.

Risk Score: A factor determined by EOHHS for use in calculating the CPCP or Shared Savings / Risk Payment, to reflect the age, sex, diagnoses or other characteristics of Contractor's Panel.

Risk Track: For the Shared Savings / Risk component of the PCPRI payment model, one of three options with varying levels of Shared Savings and financial risk, as follows: Risk Track 1 (Upside / Downside Risk); Risk Track 2 (Transitioning to Downside Risk); and Risk Track 3 (Downside Risk), and as further described in **Section 5.4** of the RFA.

Shared Losses: The portion of the difference between Target Spend and Actual Spend that is to be paid by Contractor to EOHHS.

Shared Savings: The portion of the difference between Target Spend and Actual Spend that is to be paid by EOHHS to Contractor.

Shared Savings Included Services: The set of services considered when EOHHS calculates Shared Savings / Risk Payments.

Shared Savings / Risk Performance Score: A score calculated by EOHHS based on performance on Quality Measures to be used for Shared Savings / Risk Payments.

Shared Savings / Risk Payments: The amount paid by EOHHS to Contractor in the event of Shared Savings; or if Contractor selected Risk Track 1 or Risk Track 2 in its Response, the amount owed by Contractor to EOHHS in the event of Shared Losses.

Target Spend: Projected average expenditures on Shared Savings Included Services by MassHealth and the MCOs for Contractor's Panel Enrollees.

Target Spend for PCC Panel Enrollees: Projected average MassHealth expenditures on Shared Savings Included Services as defined in **Section 4.3.D** of this Contract Addendum.

Upside Risk: The risk taken on by Contractor for which Contractor shall receive a portion of Shared Savings if Target Spend exceeds Actual Spend.

Year 1 of the Contract Addendum ("Year 1"): The period from March 1, 2014 – December 31, 2014.

Year 2 of the Contract Addendum ("Year 2"): The period from January 1, 2015 – December 31, 2015.

Year 3 of the Contract Addendum ("Year 3"): The period from January 1, 2016 – December 31, 2016.

Zero Paid Claims: Claims submitted by Participants for services covered by the CPCP that Participants provide to Panel Enrollees on their panels or the panels of their pooled affiliates, which will be paid zero dollars as described in **Section 3.4.E** of this Contract Addendum.

SECTION 2. PCPRI ELIGIBILITY

Section 2.1 Eligibility Requirements

A. As described in **Section 2.4** of the RFA, each Participating Practice Site shall, as of the Effective Date of this Contract Addendum and at all times during the term of the Contract Addendum:

1. Have a PCC Contract and meet all requirements to be a PCC as set forth in 130 CMR 450.118;
2. Have achieved Meaningful Use Stage 1 standards or other information technology standards as detailed in **Section 2.4.B.1** of the RFA; if Contractor indicated in its Application, pursuant to **Section 2.4.B.1.c.** of the RFA, that Contractor planned to achieve Meaningful Use Stage 1 standards by October 1, 2014, Contractor shall achieve such standards by October 1, 2014 and shall submit evidence to EOHHS, satisfactory to EOHHS, demonstrating such achievement by November 1, 2014.
3. Have information technology tools and functionality to support quality care and quality improvement ("QI") infrastructure as described in **Section 2.4.B.2** of the RFA, including:

    a. An EMR system with Patient Registry functionality, including the capability to produce at least one report to support evidence based protocols for chronic disease management and at least one report to support evidence based guidelines for preventative care;

    b. An information technology system that provides documentation of treatment plans, through a visit note or another mechanism; and

    c. An EMR system with the capacity to identify and assign a Primary Care Provider, to each Panel Enrollee.

4. Have the ability to provide Panel Enrollees with access, by phone or in person, at all times (24 hours per day / 7 days per week) to a provider that has prescribing authority and access to Panel Enrollees' medical records.

B. As described in **Sections 2.4 and 2.5** of the RFA, Contractor shall have, as of the Effective Date of this Contract Addendum, and shall accept at all times during the term of the Contract Addendum:

1. A minimum of 500 Panel Enrollees on Contractor's Panel, or pooled with the Panels of Pooled Participants as selected by Contractor in its Response, across the PCC Plan and MCO program; and
2. A minimum of either:

    a. 3,000 Panel Enrollees on Contractor's Panel, or pooled with the Panels of Pooled Participants as selected by Contractor in its Response or selected by EOHHS, if Contractor selected Risk Track 3; or

b. 5,000 Panel Enrollees on Contractor's Panel, or pooled with the Panels of Pooled Participants as selected by Contractor in its Response or selected by EOHHS, if Contractor selected Risk Track 1 or Risk Track 2.

C. For the purpose of EOHHS's calculation of the Quality Incentive Payments and Shared Savings / Risk Payments pursuant to **Sections 4.2 and 4.3** of this Contract Addendum, Contractor, independently, or with any Pooled Participants, shall have at least the minimum number of Panel Enrollees for Contractor's selected Risk Track as described in **Section 2.1.B.2** of this Contract Addendum.

D. If EOHHS becomes aware that the number of Panel Enrollees of Contractor or Contractor and its Pooled Participants, as applicable, has fallen below the required minimum Panel Enrollee threshold for Contractor's selected Risk Track, EOHHS may issue a warning to the Contractor and the Pooled Participants. If, in any Year of the Contract Addendum (e.g., Year 1), for more than six months of the Year, the Contractor or Contractor and its Pooled Participants do not meet the minimum Panel Enrollee thresholds of Contractor's selected Risk Track, then the following shall apply:

1. If, for Years 2 and 3, Contractor and any Pooled Participants selected Risk Tracks 1 or 2 (involving Downside Risk) for such Year, EOHHS shall pool Contractor with other participants to meet the minimum Panel Enrollee thresholds for those Risk Tracks. Such pooling shall be based on geography to the extent reasonably possible, and EOHHS shall inform Contractor of this pooling before the start of the Year.
2. If Contractor and any Pooled Participants are not taking on Downside Risk for such Year (e.g., in Track 2 before transition to Downside Risk, or Track 3) and retain an aggregate of at least 2,500 Panel Enrollees, EOHHS shall not modify Contractor's or its Pooled Participants' selected Risk Track;
3. If Contractor and any Pooled Participants are not taking on Downside Risk for such Year (e.g., in Track 2 before transition to Downside Risk, or Track 3) and do not retain an aggregate of at least 2,500 Panel Enrollees, EOHHS shall pool Contractor and any Pooled Participants with other Participants, based on geography to the extent reasonably possible, for such Year.

Section 2.2 Additional Requirements Related to CPCP Tier Selection

A. If Contractor has selected CPCP Tier 2 for some or all of its Participating Practice Sites in its Application or, pursuant to **Section 3.1.A.1** of this Contract Addendum, changes to CPCP Tier 2 for Years 2 or 3, Contractor shall, for each Participating Practice Site for which CPCP Tier 2 was selected, as of the commencement date of CPCP Tier 2 and from that date until the termination of the Contract Addendum:

1. Maintain a master's or doctoral level Behavioral Health Provider who is co-located at each Participating Practice Site, for no less than 40 hours per week; and
2. Possess the ability to schedule "first available" Behavioral Health Services appointments with a master's or doctoral level Behavioral Health Provider at each Participating Practice Site within 14 days from time of request.

B. If Contractor has selected CPCP Tier 3 for some or all of its Participating Practice Sites in its Application or, pursuant to **Section 3.1.A.1** of this Contract Addendum, changes to CPCP Tier 3 for Years 2 or 3, Contractor shall, for each Participating Practice Site for which CPCP Tier 3 was selected, as of the commencement date of CPCP Tier 3 and from that date until the termination of the Contract Addendum:

1. Meet all requirements from CPCP Tier 2, as set forth in **Section 2.2.A** of this Contract Addendum;
2. Maintain a psychiatrist, either internally or through a contractual arrangement, who is co-located with Contractor, as part of the Multidisciplinary Care Team, for at least 8 hours a week;
3. Maintain a written agreement between Contractor and one or more of Contractor's Behavioral Health Providers or internal protocol document, as applicable, evidencing that Contractor meets the access standard of providing 24 hour / 7 day per week coverage for Panel Enrollees to a Behavioral Health Provider; and
4. Maintain a written agreement between Contractor and one or more of Contractor's Behavioral Health Providers or internal protocol document, as applicable, evidencing that Contractor has 24 hour / 7 day per week access to the following components of the Behavioral Health record, for each Panel Enrollee:

    a. Diagnosis (or diagnoses, as applicable);

    b. Medication; and

    c. Acute safety issues.

C. EOHHS reserves the right to:

1. Deny Contractor's request for a change of CPCP Tier that is different from that indicated in Contractor's Application; and
2. Change Contractor's or its Participating Practice Site's CPCP Tier, in the event that Contractor or its Participating Practice Site fails to meet the criteria for receiving that CPCP Tier, including, but not limited to, any reduction in Behavioral Health Services provision by Contractor or Contractor's Behavioral Health Providers pursuant to **Section 3.1.B** of this Contract Addendum.

D. If Contractor has selected CPCP Tier 2 or 3 for some or all of its Participating Practice Sites in its Response or, pursuant to **Section 3.1.A.1** of this Contract Addendum, changes to CPCP Tier 2 for Years 2 or 3, as of the commencement date of that CPCP Tier and from that date until the termination of the Contract Addendum, Contractor shall comply with the following:

1. Except as permitted by **Section 2.2.D.2** of this Contract Addendum, Contractor shall, for each Participating Practice Site that selected such CPCP Tier 2 or 3, have a contract or contract amendment with the BH Vendor for the payment of the portion of the CPCP Rate that is based on CPCP Covered Services in Tier 2 or 3 by the BH Vendor as required by **Section 4.1** of this Contract Addendum and **Section 5.2.B** of the RFA.

2. If Contractor provides some or all of the CPCP Covered Services in CPCP Tier 2 or 3 through one or more of Contractor's Behavioral Health Providers, such Behavioral Health Providers must meet all credentialing requirements of the BH Vendor to participate in the BH Vendor's provider network and must enter into a contract or contract amendment with the BH Vendor as described in **Section 2.2.D.1** of this Contract Addendum.

Section 2.3 Notification

The Contractor shall:

A. Notify EOHHS in writing and withdraw from the PCPRI if, at any time during the term of the PCPRI, Contractor no longer meets the PCC eligibility and participation requirements at 130 C.M.R. 450.118 or the requirements for eligibility for participation in the PCPRI as set forth in **Section 2** of the RFA.

B. Notify EOHHS in writing prior to making any change in its relationship with Pooled Participants that affect the minimum number of Panel Enrollees for purposes of the PCPRI; provided further, that Contractor agrees and acknowledges that such change shall constitute cause permitting termination of its participation in the PCPRI and of this Contract Addendum pursuant to **Section 6.1** of this Contract Addendum (Termination for Cause), at the discretion of EOHHS.

C. Notify EOHHS in writing of the following changes within the timeframes set forth below:

1. Fourteen days prior to Contractor's termination of a Clinical Care Manager's employment or contract or, if Contractor does not receive 14 days' notice from the Clinical Care Manager, as soon as practicable after receiving such notice; or
2. At least 14 days prior to any of the following material changes in Contractor's corporate organization structure or practice composition occurs:

    a. Contractor merges with another practice or organization;

    b. Contractor acquires another practice or organization;

    c. Contractor eliminates a Participating Practice Site; or

    d. Change in ownership of Contractor.

EOHHS reserves the right to determine that a change indicated or made pursuant to this subsection constitutes cause for termination in accordance with **Section 6.1** (Termination for Cause) of this Contract Addendum.

SECTION 3. CONTRACTOR RESPONSIBILITIES

The requirements indicated below shall apply to Contractor in all CPCP Tiers, Behavioral Health Options, and Risk Tracks, unless otherwise indicated. Contractor agrees to be bound by all of the selections made by Contractor in its Response, including the Application to Participate in the PCPRI (**Attachment I** to the RFA), and all applicable legal requirements. Such selections include, but are not limited to, Risk Track, CPCP Tier, Behavioral Health Option, and Long Term Services and Supports. Contractor further agrees to abide by its representations and certifications made in its Certification Statement (**Attachment F** to the RFA).

Section 3.1 Clinical and Behavioral Health Integration

A. Clinical

1. As of the Operational Start Date, Contractor shall

    a. Agree to be bound to Contractor's selected CPCP Tier or Tiers for the term of this Contract Addendum as indicated in Contractor's Response, except as provided below.

        1) For Year 1, Contractor shall not be permitted to switch CPCP Tiers.

        2) For Years 2 and 3, Contractor may request a different CPCP Tier than it selected for Year 1 by submitting a written request to EOHHS by October 1, 2014 or October 1, 2015, respectively. EOHHS shall approve Contractor's request to change CPCP Tiers if Contractor demonstrates it has the ability to provide the services required by the respective CPCP Tier, to the satisfaction of EOHHS, in its sole discretion.

        3) If Contractor requests to change to a higher-level CPCP Tier for Years 2 or 3 (that is, from CPCP Tier 1 to CPCP Tier 2 or CPCP Tier 3, or from CPCP Tier 2 to CPCP Tier 3), Contractor shall provide EOHHS with evidence deemed satisfactory to EOHHS, in its sole discretion, that Contractor is able to provide, either internally or through contractual arrangements, the CPCP Covered Services for the CPCP Tier it is seeking to elect and demonstrates it meets the additional requirements for CPCP Tier 2 or 3 as described in **Sections 2.4.C.1 or 2** of the RFA, respectively.

        4) If such change in CPCP Tier for Year 2 or 3 is approved by EOHHS, payments for the new CPCP Tier shall begin on January 1, 2015 or January 1, 2016, respectively.

    b. Provide, either internally or through contractual arrangements, all of the CPCP Covered Services as listed in Attachment C and the designated services listed on Attachment K for the applicable CPCP Tier, of the RFA.

    c. Ensure compliance with all requirements for Early Periodic Screening, Diagnosis and Treatment (EPSDT), including compliance with MassHealth's EPSDT Periodicity Schedule.

2. By six months after the Operational Start Date, Contractor shall:

    a. Employ or provide through contractual arrangement, a Clinical Care Manager to coordinate and provide Clinical Care Management services. The Clinical Care Manager shall be a licensed clinical professional, and must be closely integrated with the Multidisciplinary Care Team, with a strong preference for co-location. The Clinical Care Manager's job duties, shall include, but are not limited to:

        1) Identifying Highest Risk Panel Enrollees; and

        2) Providing and coordinating Clinical Care Management services for Highest Risk Panel Enrollees, including managing the development, implementation and monitoring of the Integrated Care Plans.

    b. Track the Behavioral Health screening and results of pediatric and adolescent Panel Enrollees using the EMR.

3. By 12 months after the Operational Start Date, Contractor shall:

    a. Identify a Multidisciplinary Care Team and a team leader for each Panel Enrollee. The Multidisciplinary Care Team shall meet on a regular basis as determined by Panel Enrollee needs to plan and coordinate care for each Panel Enrollee as appropriate, to review quality improvement data and to review and improve team functioning.

    b. Have in place one or more written agreements between Contractor and individual or organizational Behavioral Health Providers, if such agreements are necessary to facilitate the PCPRI requirements to coordinate care and integrate Primary Care and Behavioral Health Services for Panel Enrollees. Each agreement shall include specifications as appropriate for access expectations between providers, protocols for joint problem solving, information sharing, Care Coordination/Clinical Care Management and provider-to-provider consultations.

    c. Demonstrate Behavioral Health integration to EOHHS, either through agreements noted in subsection (b) or through other means.

    d. Utilize its Patient Registry to monitor and manage care for at least three chronic diseases, including one Behavioral Health condition, that are most prevalent among Contractor's Panel.

    e. Screen and utilize the EMR to track adult Panel Enrollees for Behavioral Health conditions at annual physician examinations using a standardized tool (depression, anxiety, substance use, intimate partner violence, suicide risk and symptoms of trauma) and include bio-psychosocial and quality of life assessments.

    f. Be connected to the Mass Hiway through a direct-enabled EMR system or a local area network device (LAND).

g. Have the majority of providers who render primary care services to Panel Enrollees attest to Meaningful Use Stage 2 requirements from the Centers for Medicare and Medicaid Services, if applicable, unless the Contractor is not eligible for HIT incentive payments due to its status as a pediatric practice with an insufficient Medicaid volume or provider has not been qualified as Meaningful Use Stage 1 long enough yet to apply for Meaningful Use Stage 2.

4. By 18 months after the Operational Start Date, Contractor shall:

   a. Provide Panel Enrollees with timely access to Behavioral Health Providers, based on Panel Enrollee need and acuity at all times (24 hours per day, seven days per week).

      1) For urgent Panel Enrollee needs pertaining to Behavioral Health:

         a) If Contractor selected CPCP Tier 1 or 2 for some or all of its Participating Practice Sites in its Response, Contractor shall, for each Participating Practice Site that selected such CPCP Tier, make its best efforts to provide Panel Enrollees with a consultation visit, in person or through alternative access mechanisms, such as phone or videoconference, with a licensed Behavioral Health Provider within 48 hours of the Panel Enrollee's request (or request made on behalf of an Panel Enrollee); such best efforts shall be evidenced by documentation that Contractor at a minimum contacted and attempted to schedule the Panel Enrollee visit within the required timeframe with three licensed Behavioral Health Providers and contacted the appropriate managed care entity.

         b) If Contractor selected CPCP Tier 3 for some or all of its Participating Practice Sites in its Response, Contractor shall, for each Participating Practice Site that selected such CPCP Tier, provide Panel Enrollee with a consultation visit, in person or through alternative access mechanisms, with a licensed Behavioral Health Provider within 48 hours of the Panel Enrollee's request.

      2) For all other Panel Enrollee needs pertaining to Behavioral Health, Contractor shall provide Panel Enrollees with an in-person visit with a Behavioral Health Provider that is a member of the Multidisciplinary Care Team within 14 calendar days of the Panel Enrollee's request (or request made on behalf of a Panel Enrollee).

   b. Operate as a Patient-Centered Medical Home by meeting the ten Patient-Centered Medical Home Components of **Section 3.1.B** of the RFA and, as described below.

      1) In order to demonstrate Patient-Centeredness, Contractor shall:

         a) Deliver longitudinal care with transparency, individualization, recognition, awareness of the socio-demographic factors that contribute to health disparities, respect, linguistic and cultural competence, and dignity.

b) Regularly solicit feedback from Panel Enrollees on its care delivery, as well as its quality improvement and Panel Enrollee safety activities. Feedback may be received through a Panel Enrollee survey, the establishment of a Panel Enrollee / consumer advisory council, Panel Enrollee / consumer participation in a Contractor's board of directors, Panel Enrollee participation in quality improvement teams and / or other modalities.

c) Collaborate with Panel Enrollees, the Panel Enrollee's legally authorized representative, youth and key caretakers in pediatrics and, in accordance with Panel Enrollee wishes, encourage the participation of spouses, significant others, and appropriate family members in the development and implementation of treatment plans.

d) Demonstrate specific competencies in pediatrics and behavioral needs of children, as appropriate to the needs of Contractor's Panel.

e) Establish patient safety protocols.

f) Train the Multidisciplinary Care Team members on safe medication practices, including comprehensive medication reconciliation for both physical and Behavioral Health medications.

g) Screen and manage Panel Enrollees for suicide and public safety risks.

h) Have the functional capacity for and operationalize electronic prescribing (e-prescribing) to permit more accurate medication reconciliation. E-prescribing functionality shall include electronic transmission of prescriptions, EMR documentation of accurate lists of medications prescribed, and alerts for drug interactions and allergies.

i) Educate the Panel Enrollees and their family members on primary preventive care and self-management of chronic illness (i.e., secondary preventive care).

j) Allow each Panel Enrollee to be actively involved in planning his or her care, including goal setting, action planning, problem-solving and follow-up, and documentation of Panel Enrollee's involvement in his or her care.

k) Support the Panel Enrollee in care planning and provide documentation of Panel Enrollee's involvement in his or her care.

2) In order to demonstrate a Multidisciplinary Care Team-based Approach to care, Contractor shall:

a) Use a Multidisciplinary Care Team-based approach to coordinating and delivering care to Panel Enrollees.

b) Identify a Multidisciplinary Care Team for each Panel Enrollee according to the Panel Enrollee's needs. In all cases, the Multidisciplinary Care Team shall include a Primary Care Provider. For Highest Risk Panel Enrollees, the

Multidisciplinary Care Team shall include a Clinical Care Manager and, as needed, a Behavioral Health Provider. In addition, the Multidisciplinary Care Team may include, as appropriate to the Panel Enrollee's needs, a Behavioral Health Provider, and a nurse, medical assistant, Peer partner and/or any other clinical support or allied professional staff. Primary Care Providers and Behavioral Health Providers shall be part of the same Multidisciplinary Care Team.

c) Identify a leader of the Multidisciplinary Care Team based on Panel Enrollee preference and the Panel Enrollee's primary locus of care. The team leader shall be responsible for ensuring that Multidisciplinary Care Team members are fulfilling their roles in support of the Panel Enrollee's care.

d) Ensure that Behavioral Health Providers on the Multidisciplinary Care Team, during interactions with Panel Enrollees, routinely play a role in monitoring Panel Enrollees' physical condition on behalf of the Multidisciplinary Care Team. This role may include asking about and monitoring for adverse effects of prescribed medications and new physical symptoms that have not been reported to the Multidisciplinary Care Team, or addressing Panel Enrollees' understanding of their diagnoses and treatments.

e) Ensure that Primary Care Providers and other members of the Primary Care team routinely screen for common Behavioral Health conditions and that members of the Multidisciplinary Care Team have been trained in skills to promote positive Behavioral Health change. Such skills shall include motivational interviewing, relapse prevention planning, setting and supporting self-management goals and basic knowledge of Behavioral Health referral sites to enhance delivery of evidence-based interventions, in consultation with Behavioral Health Providers.

3) In order to demonstrate Planned Visits and Follow-up Care, Contractor shall:

a) Track each Panel Enrollee's care on an ongoing basis, such as delivering care pro-actively, using data to guide care delivery. Data may focus on: visits, including visits to external providers such as hospitals and specialists, completion of evidence-based chronic disease monitoring and preventive screenings, and an assessment of the status of implementation of the treatment plan.

b) Employ specified outreach efforts for Panel Enrollees with frequent failures to keep appointments, complicated medical regimens, low health literacy, and / or who are in periods of severe stress or risk.

c) To engage Panel Enrollees from diverse cultural, ethnic, linguistic, and socio-demographic backgrounds, employ outreach efforts that require competencies that involve a range of professional and paraprofessional staff.

d) Ensure that care is evidence-based wherever evidence exists, and the treating clinicians follow stepped care protocols for the treatment of illness.

e) Implement evidence-based care protocols for the management of Panel Enrollees with chronic illnesses and for preventive care that include Behavioral Health elements of care, including but not limited to support for behavioral change.

f) Ensure that adult Panel Enrollees are routinely screened prior to or during annual physical exams with a standardized tool for depression, anxiety, substance use, intimate partner violence, suicide risk and exposure to and symptoms of trauma. Screening shall also include bio-psychosocial and quality of life assessments.

g) Ensure that pediatric and adolescent Panel Enrollees are routinely screened in accordance with MassHealth's EPSDT Periodicity Schedule.

4) In order to demonstrate Population-based Tracking and Analysis with Patient-specific Reminders, Contractor shall:

a) Have and utilize information tracking capacity in the form of an EMR and Patient Registry with reporting functionality. In addition to documenting clinical care, the EMR shall have decision supports to prompt adherence to evidence-based guidelines and the functionality to generate lists of Panel Enrollees to proactively remind Panel Enrollees/families and clinicians of services needed, which may be related to preventive, chronic or acute care.

5) In order to demonstrate Care Coordination across settings, including referral and transition, Contractor shall:

a) Assume responsibility for tracking and assisting Panel Enrollees as they move across care settings and for coordinating services with other service providers, including Behavioral Health, specialty care, inpatient care, social service, and long-term care providers. Services may also include non-clinical supports available in the community.

b) Establish systems for responding appropriately in a timely manner when notified of Panel Enrollees' admissions, discharges and emergency department visits through any mechanisms, including direct communications from a hospital or information received through a payer.

c) Ensure that the exchange of Panel Enrollee information among providers across settings keeps the Multidisciplinary Care Team informed of Panel Enrollees' health status and whereabouts.

d) Provide for smooth transitions between the Multidisciplinary Care Team Members and health care providers treating Panel Enrollees for same day or urgent visits and, where possible, in-person introductions of Multidisciplinary Care Team members to Panel Enrollees for same day or urgent visits.

e) Ensure that Primary Care and Contractor's Behavioral Health Providers have referral and information-sharing protocols, which specify access expectations, include plans for problem solving and coordination, and include mechanisms for documenting patient consent for information sharing when such consent is required by law.

6) In order to demonstrate Clinical Care Management services focused on Highest Risk Panel Enrollees, Contractor shall:

a) Identify Highest Risk Panel Enrollees (in addition to the list provided by EOHHS) among its Panel based on a consistent approach to determining patient complexity, risk and patterns of effective or duplicative care and ongoing review of the Patient Registry. Such identification process shall take into account bio-psychosocial factors which may include (1) the number, type and severity of diseases and conditions; and (2) social factors that may complicate care delivery and impact health outcomes, such as homelessness, refugee or immigrant status, criminal justice involvement, food insecurity, or other factors. In addition, the identification process may also take into account Panel Enrollee demographics, hospitalizations and utilization of the emergency department, specialty services and pharmacy.

b) Provide Clinical Care Management for all Highest Risk Panel Enrollees identified by EOHHS and Contractor. Clinical Care Management shall include frequent contact with the Highest Risk Panel Enrollees, clinical assessment, medication reconciliation, communication with treating professionals, brief behavioral patient activation interventions, Panel Enrollee teaching, and development and implementation of the Integrated Care Plan.

c) Ensure that each Highest Risk Panel Enrollee is assigned to a Clinical Care Manager to coordinate and provide Clinical Care Management services. The Clinical Care Manager may be an employee or contractor of Contractor or of another organization as may be appropriate to meet the Panel Enrollee's needs. The Clinical Care Manager shall be closely integrated with the Multidisciplinary Care Team, with a strong preference for co-location. The Clinical Care Manager shall:

(i) Develop, implement, and coordinate the Panel Enrollee's Integrated Care Plan, which includes medical and Behavioral Health goals and which delineates the roles and responsibilities of care providers.

(ii) Document the Integrated Care Plan in the Panel Enrollee's record and update the Integrated Care Plan on an ongoing basis, as necessary.

(iii) Coordinate care among providers from systems of care, including Department of Mental Health and Department of Children and Families.

(iv) Use Behavioral Health skills, including motivational interviewing, relapse prevention planning, and setting and supporting self-management goals, as

may be required when helping Panel Enrollees implement their Integrated Care Plans.

(v) Maintain awareness of medical and Behavioral Health-focused resources within Contractor and community and regularly connects Panel Enrollees to those resources.

7) In order to demonstrate Self-management Support by members of the Multidisciplinary Care Team, Contractor shall:

a) Assist the Panel Enrollee and the Panel Enrollee's support system with the challenges of ongoing disease self-management, directly or through referral.

b) Have organized resources to help Panel Enrollees identify their strengths and to understand and utilize existing community supports to complement the medical and Behavioral Health Services provided. Community supports may include, but are not limited to, self-help groups, social service and civic agencies, and spiritual supports.

c) Offer books, pamphlets, websites or other resources that foster Panel Enrollee self-help.

8) In order to demonstrate Integration of Quality Improvement Strategies and Techniques, Contractor shall utilize a quality improvement model to measure performance, identify opportunities for improvement, test interventions, and reassess performance. Elements of the quality improvement program shall be documented and shall include Panel Enrollee safety, satisfaction and outcomes.

9) In order to demonstrate Enhanced Access to Services, Contractor shall:

a) Provide ease and flexibility of Panel Enrollee access to the Multidisciplinary Care Team, including 24 hours per day / seven days per week practice coverage and one or more of the following approaches to enhanced access: visits outside of "normal business hours," e-mail, telephone contact, telemedicine, or group visits.

b) Provide Panel Enrollees with timely access, based on need and acuity, to behavior change support, Behavioral Health Services and Primary Care Services.

c) Demonstrate awareness of same-day mobile crisis services and other emergency evaluations available to Panel Enrollees, and shall develop plans to educate Panel Enrollees about these services.

d) Have the capability to schedule a Behavioral Health visit and / or Primary Care visit for a Panel Enrollee at the time of the Panel Enrollee visit.

10) In order to demonstrate Clinic System Integration, Contractor shall:

a) Collaborate with Contractor's Behavioral Health Providers to promote integration broadly across the organization(s). This collaboration shall include Primary Care and Behavioral Health staff collaborating on developing protocols, standards of practice, memorandums of understanding as needed, and interventions to ensure successful communication and integration. In addition, Contractor's leadership shall ensure that clinical and non-clinical staff members are trained on the importance of integration and their roles in supporting it, and shall provide operational support for integration in terms of scheduling, reception, administration, staffing and facilities.

b) Ensure that information from Panel Enrollee visits and communications with Panel Enrollees are shared between Contractor and Contractor's Behavioral Health Providers. This sharing may involve having a single Panel Enrollee health record utilized by both the Contractor and Contractor's Behavioral Health Providers, to the extent possible and given required compliance with federal and state privacy laws and Panel Enrollee consent.

c. By 24 months after the Operational Stat Date, the PCPR Contractor shall:

1) Submit to EOHHS evidence that Contractor has received National Committee for Quality Assurance (NCQA) recognition as a Level 1 PCMH. If the Massachusetts Health Policy Commission, established pursuant to Chapter 224 of the Acts of 2012, determines standards for PCMH certification that comport with the objectives of the PCPRI, EOHHS may, in its sole discretion, accept evidence of such certification to meet this requirement.

B. Approach to Integration of Behavioral Health

To comply with the Behavioral Health Integration requirements described in **Section 3.1.I** of the RFA, Contractor shall:

1. Notify EOHHS in writing of any changes or plans to change its approach to Behavioral Health Integration or selection of Behavioral Health Option in Contractor's Application. Specifically, Contractor shall notify EOHHS if it plans to change its Behavioral Health Option from one level on the continuum of care to another (Non- Co-Located but Coordinated; Co-located; or Clinically Integrated), as described in **Section 3.1.I** of the RFA.
2. Receive prior written approval from EOHHS before changing the approach to Behavioral Health Integration or selection of Behavioral Health Option that Contractor indicated in its Application to the RFA.

Section 3.2 Quality Measures

A. To comply with the Quality Measures and Metrics requirements as described in **Section 4** of the RFA, Contractor shall:

1. Collect, track, record, and submit the data needed to report on each of the Quality Measures set forth in **Attachment A** to this Contract Addendum, in the manner, method, and timeframes set forth therein.

    a. Contractor shall report on a quarterly basis or as otherwise specified by EOHHS on the Quality Measures as listed in **Attachment A** to this Contract Addendum for which the source of data is listed as the "Medical Record." (See column entitled, "Data Collection Options," in Table A1 of **Attachment A** to this Contract Addendum).

    b. By June 1, 2014, Contractor shall provide a report on the Quality Measures for the four quarters of Calendar Year 2012 and the four quarters of Calendar Year 2013 as listed in **Attachment A** to this Contract Addendum for which the source of data is listed as the "Medical Record". (See column entitled, "Data Collection Options," in Table A1 of **Attachment A**).

    c. In some cases, as listed in **Attachment A** to this Contract Addendum, Contractor may choose to submit claims with CPT II and G codes as an alternative means to reporting the Quality Measure.

2. Perform on the Quality Measures set forth in **Attachment A** to this Contract Addendum, in accordance with the timeframes set forth therein.
3. Report on any Quality Measures added as amendments to this Contract Addendum after the Effective Date.

    a. Before new Quality Measures based on Contractor reports which are added after the Effective Date are used to calculate Quality Incentive Payments or modify Shared Savings / Risk Payments, the Contractor shall report on such Quality Measures for a period of one year. Claims based Quality Measures may be used by EOHHS to calculate Quality Incentive Payments or modify Shared Savings / Risk Payments at any time.

B. EOHHS shall determine whether Contractor's reporting of Quality Measures is satisfactory as defined by the completeness, timeliness and accuracy of the data submitted by Contractor.

C. EOHHS shall calculate the value of any Quality Incentive Payments using the approaches described in **Section 5.3** of the RFA and in accordance with **Section 4.2** of this Contract Addendum.

D. EOHHS shall make any applicable Quality Incentive Payments pursuant to **Section 5.3** of the RFA and **Section 4.2** of this Contract Addendum, and shall make any applicable Shared

Savings / Risk Payments pursuant to **Section 5.4** of the RFA and **Section 4.3** of this Contract Addendum.

E. EOHHS shall establish baseline parameters for Quality Measures to be used in Quality Incentive Payments and Shared Savings/Risk Payments in accordance with the following:

1. For each Quality Measure to be used for Quality Incentive Payments or Shared Savings / Risk Payments in a given year, prior to the start of that year, EOHHS will establish a benchmark, a threshold, and a minimum N. In general, the benchmark will be the 90th percentile of aggregate Participant performance during the baseline period and the threshold will be the 30th percentile of aggregate Participant performance during the baseline period. These percentiles will be calculated among Participants meeting the criteria for reporting the Quality Measure in the baseline period. In general, the minimum N will be 35.
2. Notwithstanding the foregoing, EOHHS may alter these parameters as necessary. EOHHS may opt to change the benchmark and threshold or set the minimum N at a higher number. EOHHS will also establish the baseline performance of Contractor.
3. At least 30 days prior to the start of each Year of the Contract Addendum in which Quality Measures will be used in Shared Savings / Risk Payments, EOHHS will establish the thresholds that will be used to categorize Shared Savings / Risk Performance Scores as Excellent, Good, Fair, and Poor. For each Quality Measure included in the Shared Savings / Risk Performance Score, EOHHS will establish the minimum level of performance considered satisfactory. The threshold that delineates Poor performance will correspond to the score attained when every Quality Measure is at this minimum level. The remaining two thresholds (distinguishing Fair from Good and Good from Excellent) will be established to divide the remaining Participants into three, roughly equal groups, based on attainment scores among Participants in the period during which the measure was a P4R measure. EOHHS may use its discretion in setting thresholds, particularly in setting the threshold that distinguishes Poor performance.

F. In order to calculate the P4Q Total Performance Score, EOHHS shall take the following steps:

1. For each age group (pediatric and adult):

    a. Determine the number of eligible Quality Measures, defined as the number of Quality Measures to be used for P4Q for the age group (pediatric or adult) for which the number of Panel Enrollees meeting the eligibility criteria during the measurement period exceeds the minimum N.

    b. For each eligible Quality Measure, calculate Contractor's attainment score, defined as (Pj-T)/(B-T) and Contractor's improvement score, defined as ((Pj-Pjb)/(B- Pjb)). In these formulas, Pj represents the value of the measure for Contractor during the performance period, T represents the threshold, B represents the benchmark, and Pjb represents the value of the measure for Contractor during the baseline period. In the event that Contractor's number of Panel Enrollees meeting the eligibility criteria

during the baseline period is less than the minimum N, Contractor's improvement score will not be calculated.

c. For each eligible Quality Measure, define the Quality Measure score as the greater of the attainment or improvement score.

d. Calculate the performance score for the age group as the sum of the Quality Measure scores divided by the number of eligible Quality Measures.

2. Calculate the P4Q Total Performance Score as a weighted average of the performance scores for each age group. The percentage of Contractor's Panel Enrollees in each age group will be used as the weights for the weighted average.

3. The resulting P4Q Total Performance Score will vary between zero and one, with a value of zero if the values of all Quality Measures were below the threshold and no improvement was observed between the baseline and the performance period and a value of one if the value of all Quality Measures was at or above the benchmark.

G. EOHHS shall calculate the Shared Savings / Risk (SS / R) Performance Score in accordance with the following:

1. The SS / R Performance Score will be calculated in the same manner as the P4Q Total Performance Score but will be based on the Quality Measures to be used for the Shared Savings / Risk Payments rather than the Quality Measures to be used for the Quality Incentive Payments.

2. The SS / R Performance Scores will then be mapped into the following categories: Excellent, Good, Fair, and Poor as described above in **subsection E**.

3. If necessary, EOHHS may modify this formula to meet PCPRI program goals. For example, for P4Q Total Performance Scores, EOHHS intends that at least 75% of Participants achieve scores greater than zero and, for SS / R Performance Scores, EOHHS intends that fewer than 10% of Participants are in the Poor category and that Participants are roughly evenly distributed across the three remaining categories.

Section 3.3 Panel Enrollee Protections

The Contractor shall ensure that:

A. Each Panel Enrollee is notified that the Panel Enrollee is free to enroll with a Primary Care Provider other than Contractor at any time, and may enroll with a Primary Care Provider that is not participating in the PCPRI.

B. Each Panel Enrollee is notified that the Panel Enrollee is free to choose a Behavioral Health Provider that is not Contractor's Behavioral Health Provider.

C. Contractor does not restrict or deny medically necessary care to any Panel Enrollee, and provides referrals to specialty services as clinically indicated.

D. Contractor complies with all applicable state and federal laws and regulations, including those relating to Panel Enrollee confidentiality and privacy and, specifically, as applicable to the sharing of Panel Enrollee information between Contractor and Contractor's Behavioral Health Providers.

E. Upon request by EOHHS, Contractor facilitates the collection of Panel Enrollee feedback by administering patient experience surveys and shall encourage its Panel Enrollees to respond to such surveys.

Section 3.4 Administrative Compliance

As described in **Section 7** of the RFA and in addition to its other obligations under this Contract Addendum, Contractor shall perform certain administrative functions as more fully detailed below. Contractor shall:

A. Notify Panel Enrollees on its Panel that Contractor is participating in the PCPRI and any additional information required by EOHHS, utilizing either a standard form containing language prepared and provided by EOHHS (which may be placed on Contractor's letterhead), or alternative language proposed by Contractor and approved by EOHHS prior to use by Contractor.

B. Notify each Panel Enrollee on its Panel if and when Contractor is no longer participating in the PCPRI.

C. As a condition of continuing payment and program participation, comply with all applicable Massachusetts and federal laws and regulations, as may be amended from time to time; such compliance includes but shall not be limited to compliance with all applicable federal laws and regulations designed to prevent fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq), and the anti-kickback statute (42 U.S.C. section 1320a-7b(b)).

D. Perform contract management activities as follows:

1. The Contractor shall:

    a. Maintain all contracts with Contractor's Behavioral Health Providers and Material Subcontractors related to this Contract Addendum in writing;

    b. Remain fully responsible for meeting all of the terms and requirements of this Contract Addendum regardless of whether Contractor affiliates or subcontracts for performance of any Contract Addendum responsibility;

    c. Prior to any delegation or contracting with a Material Subcontractor, evaluate the prospective affiliated entity or Material Subcontractor's ability to perform the activities to be delegated or subcontracted, and submit such evaluation to EOHHS if requested;

d. Monitor any Contractor's Behavioral Health Providers and Material Subcontractor's performance on an ongoing basis;

e. Hire Material Subcontractors in performing the requirements of this Contract Addendum only with EOHHS's prior approval; and

f. Submit to EOHHS, as requested, a listing and a description of all contracts that Contractor has with such Material Subcontractors, including the requirements within this Contract Addendum that will be performed by the Material Subcontractor(s).

2. The Contractor acknowledges and agrees that all material subcontracts are subject to EOHHS's approval, which may include reviewing any material subcontract documents or contracts, meeting with the prospective Material Subcontractor, or requiring resumes of the Material Subcontractor's key personnel.

3. The Contractor agrees that all material subcontracts or written arrangements shall:

   a. Contain all relevant provisions of this Contract Addendum, RFA and Commonwealth Terms and Conditions appropriate to the subcontracted service or activity;

   b. Specify, and require compliance with, all applicable requirements of this Contract Addendum and the responsibilities the Material Subcontractor is obligated to provide, and provide for imposing sanctions, including contract termination, if the Material Subcontractor's performance is inadequate;

   c. 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; and

   d. As a condition of continuing payment, specify that they comply with all applicable federal laws and regulations, and CMS instructions, including without limitation those designed to prevent fraud, waste, and abuse, including but not limited to applicable provisions of federal criminal law, the False Claims Act ((31 U.S.C. section 3729 et seq), and the anti-kickback statute (42 U.S.C. section 1320a-7b(b)).

4. The Contractor acknowledges and agrees that it is fully responsible for meeting all terms and requirements of this Contract Addendum regardless of whether Contractor subcontracts for performance of any Contract Addendum responsibility.

5. The Contractor shall serve as primary contact for this Contract Addendum, whether or not it employs the use of Material Subcontractors.

6. The Contractor shall perform an annual formal review of all Material Subcontractors' performance. If any deficiencies or areas for improvement are identified, Contractor shall require the Material Subcontractor to take corrective action. Upon request, Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result. EOHHS reserves the right to participate in any evaluation of the Material Subcontractor's performance.

7. The Contractor shall notify EOHHS in writing the same day upon notifying any Material Subcontractor, or being notified by any Material Subcontractor, of the intention to terminate such subcontract.
8. The Contractor shall submit to EOHHS an annual list of all Material Subcontractors and submit ad hoc reports, as frequently as necessary or as directed by EOHHS, with any changes to the above mentioned list.
9. The Contractor shall submit to EOHHS the following reports:

    a. Monthly allocation of Clinical Care Manager time, utilizing an EOHHS-provided template;

    b. A quarterly report on Panel Enrollees that are homeless or exposed to housing insecurity, in a form and format to be specified by EOHHS; and

    c. Other reports, as specified by EOHHS.

E. The Contractor shall submit, within 60 days of service provision, claims for all CPCP Covered Behavioral Health Services provided to a Panel Enrollee or provided to a Member enrolled with any of Contractor's Pooled Participants if Contractor pooled with other Participants pursuant to **Sections 2.5.A.1 or 2.5.H** of the RFA by Contractor or one of Contractor's Behavioral Health Providers. The Contractor shall submit, within 90 days of service provision, claims for all CPCP Covered Non-behavioral Health Services provided to a Panel Enrollee by Contractor or provided to a Member enrolled with any of Contractor's Pooled Participants if Contractor pooled with other Participants pursuant to **Sections 2.5.A.1 or 2.5.H** of the RFA by Contractor. The Contractor shall submit such claims for CPCP Covered Services in CPCP Tier 1 to EOHHS and shall submit such claims for CPCP Covered Services in CPCP Tier 2 or 3 to the BH Vendor. Because these services are reimbursed through the CPCP, EOHHS and the BH Vendor, as applicable, shall pay zero dollars for each of these claims (Zero Paid Claims), but shall not consider these claims to be denied claims. EOHHS reserves the right to audit such claims for completeness and accuracy, and to impose administrative fines or any other remedy available by law or regulation if it determines that claims data is not being submitted with sufficient completeness or accuracy.

F. The Contractor shall meet with EOHHS or its delegate on a regular basis but no less than six months after the Effective Date and every six months thereafter during the term of the Contract Addendum to provide an update on Contractor's progress against the requirements and timelines of the Contract Addendum.

    1. For each such meeting with EOHHS or its delegate, Contractor shall provide a written report (Progress Update Report), utilizing an EOHHS-provided template, on Contractor's progress against the requirements of the Contract Addendum.
    2. No later than 60 days after the termination of the Contract Addendum, Contractor shall submit to EOHHS a final progress update on Contractor's progress against the requirements of the Contract Addendum.

3. The Contractor shall incorporate into its Progress Update Reports any written comments or suggestions provided to Contractor by EOHHS or its designee; in addition, EOHHS reserves the right to review and approve each Progress Update Report.

G. The Contractor shall participate in, coordinate and provide information to facilitate an evaluation of the PCPRI, to be performed by EOHHS or its delegate. Such participation shall include, but not be limited to, the following:

1. Responding to surveys and requests for interviews of Contractor staff, Contractor's Behavioral Health Providers and Panel Enrollees, and may entail participating in and completing other activities, as requested by EOHHS.
2. Providing all requested information to EOHHS or its delegate in timeframes designated by EOHHS.

H. The Contractor shall participate in any Learning Collaborative activities required by EOHHS including, but not limited to, the following activities:

1. Webinars;
2. Conferences; and
3. Workgroup meetings.

I. The Contractor shall acknowledge and agree that Panel Enrollees shall be permitted at all times to receive CPCP Behavioral Health Covered Services from providers other than Contractor or Contractor's Behavioral Health Providers. The Contractor shall acknowledge and agree to provide referrals as necessary to Panel Enrollees for CPCP Primary Care Covered Services.

1. Contractor shall be responsible for providing referrals to appropriately qualified providers based on a Panel Enrollee's need, regardless of whether the referred provider is Contractor's Behavioral Health Provider or otherwise affiliated with Contractor.
2. Contractor shall not restrict or attempt to restrict a Panel Enrollee's care to Contractor's practice against that Panel Enrollee's wishes. If EOHHS concludes that Contractor or Contractor's Behavioral Health Providers has engaged in such prohibited activity, EOHHS may terminate Contractor from participation in the PCPRI in accordance with the termination provisions in **Section 6.1** (Termination for Cause) of this Contract Addendum.
3. If EOHHS determines that Contractor or Contractor's Behavioral Health Provider has engaged in practices that led to inappropriate denials of care or underutilization, EOHHS may impose sanctions as it deems necessary, including termination of the Contract Addendum in accordance with the termination provisions in **Section 6.1** (Termination for Cause) of this Contract Addendum.

J. The Contractor shall ensure that it does not attempt to influence the composition of its Panel by selecting low cost individuals or avoiding high cost individuals who are or seek to be Panel Enrollees; Contractor shall further ensure it does not inappropriately deny services or treatment to Panel Enrollees.

K. The Contractor shall cooperate with any on-site visits by EOHHS or its delegate, and EOHHS reserves the right to make on-site visits, consistent with the following:

1. Such on-site visits shall be on a quarterly basis or at other frequency intervals as determined by EOHHS.
2. Upon request by EOHHS or its delegate, Contractor shall produce in a timely manner such records, prescriptions, and other documentary evidence of services provided or capabilities required under this Contract Addendum, including but not limited to Contractor's utilization data, referrals and other information.

L. The Contractor shall contract with or hire a replacement Clinical Care Manager within three months of the departure of a Clinical Care Manager. Until a permanent replacement Clinical Care Manager is obtained, Contractor shall utilize other qualified staff to perform the Clinical Care Manager role or contract with an entity or individual to provide Clinical Care Management on an interim basis.

M. The Contractor shall designate a contact person to act as liaison to EOHHS for the PCPRI ("PCPRI Liaison"). The PCPRI Liaison shall, among other things, respond to EOHHS's requests for information related to the PCPRI, meet with EOHHS staff upon request to discuss issues and solve problems related to the PCPRI, and receive and properly distribute EOHHS reports and PCPRI notices from the PCC Plan.

N. 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 Addendum as they become effective.

O. The Contractor shall agree and acknowledge that the payments described and made in accordance with **Section 4 (**Payment) of this Contract Addendum below shall be payment in full for all services provided pursuant to, and obligations under, this Contract Addendum.

P. The Contractor shall, upon request by EOHHS or its delegate, produce in a timely manner information related to Contractor's corporate governance structure, leadership and staffing.

Section 3.5 Additional Requirements Related to Downside Risk

If Contractor selected Risk Track 1 or Risk Track 2 in its Application or, pursuant to **Section 4.3.E.2** of this Contract Addendum, changes or is changed by EOHHS to Risk Track 1 or Risk Track 2 for Years 2 or 3, Contractor shall, as of the commencement date of the first Contract Year for which Contractor will be in such Risk Track until the termination of the Contract Addendum, obtain and maintain in good standing a certification from the Division of Insurance (DOI) as a risk-bearing provider organization, as described in **Section 2.7** of the RFA. Notwithstanding any other provision of this Contract Addendum or the RFA, EOHHS reserves the right to require that Contractor switch from Risk Track 1 or Risk Track 2 to Risk Track 3 (Upside Risk Only) in the event that either (1) Contractor fails to obtain a risk certificate or waiver from DOI, as applicable and consistent with the provisions of **Section 2.7.A** of the RFA; or (2) otherwise appears not ready to take on risk under this Contract Addendum, in the sole discretion of EOHHS. If, pursuant to **Section 4.3.E.2**, Contractor is required to switch from Risk Track 3 to Risk Track 1 or Risk Track 2 for Contract Years 2 and 3, Contractor shall submit to

EOHHS either (1) documentation that Contractor has applied for such DOI certification or (2) a petition for exemption for good cause from the requirement to switch Risk Tracks, no later than July 1, 2014.

SECTION 4. PAYMENT

Subject to all required federal approvals, sufficient available state appropriation, and Contractor's compliance with the provisions of this Contract Addendum, EOHHS or the BH Vendor, as applicable, shall make payments to Contractor according to the terms set forth below.

Should EOHHS determine, in its sole discretion, that elements of the payment model or methodology shall not function, or are not functioning, as EOHHS expects, EOHHS may propose to amend this Contract Addendum with Contractor to adjust the payment model or methodology, subject to all required federal approvals. In Years 2 and 3 of the Contract Addendum, the Contractor must enroll in Risk Tracks 1 or 2 unless EOHHS determines otherwise for good cause. Additional amendments may include, but are not limited to, reductions in quality incentive payments and reductions in shared savings payments. Failure to accept such proposed amendments may be grounds for termination of this Contract Addendum.

Section 4.1 Comprehensive Primary Care Payment (CPCP)

A. As described in **Section 5.2** of the RFA, the Contractor shall be paid a Comprehensive Primary Care Payment (CPCP) at the CPCP Rate for Contractor's provision of CPCP Covered Services. The CPCP Rate shall be calculated as follows:

1. Contractor's CPCP Rate shall be the Base Rate multiplied by Contractor's Risk Score and Contractor's Expected External Service Provision Adjustment.
2. EOHHS shall develop a Base Rate for each provider type (Primary Care Provider (PCP), including group practice; Community Health Center (CHC); and Hospital-Licensed Health Center or Hospital Outpatient Department (HLHC/HOPD)) and each of the three CPCP Tiers of the CPCP.

    a. The Base Rate shall be a per Panel Enrollee, per month rate. EOHHS shall determine the Base Rate by taking into account:

        1) The billable services rate, a rate based on the expected average cost of providing the Primary Care and Behavioral Health Services defined in each CPCP Tier and;

        2) The Medical Home Load, a supplemental amount for the expected average non-billable cost of transforming Contractor's practice and delivery model to meet the PCPRI's Clinical Delivery Model requirements as described in **Section 3** of the RFA and the requirements of **Section 3.1** of this Contract Addendum, including Clinical Care Management and Care Coordination responsibilities.

    b. Subject to any relevant changes in federal or state laws or regulations, the Base Rate shall reflect that certain types of Medicaid providers are eligible to receive Medicare rates for a defined set of Primary Care Services, as provided in Section 1202 of the

Patient Protection and Affordable Care Act, between January 1, 2013 and December 31, 2014.

3. EOHHS shall calculate a Risk Score for Contractor based on the age, sex, diagnoses and other characteristics of Contractor's Panel and Contractor's selected CPCP Tier, including the selected CPCP Tier for each of Contractor's Participating Practice Sites. The Risk Score shall be calculated in accordance with an established risk adjustment model to be chosen by EOHHS.
4. EOHHS shall determine each Contractor's Expected External Service Provision Adjustment as a percentage of the CPCP Rate and shall take this factor into account when calculating Contractor's CPCP Rate and adjust the CPCP Rate accordingly.

    a. To establish each Contractor's Expected External Service Provision Adjustment, EOHHS shall determine, based on historical data from Contractor's Panel, the expected Fee-For-Service billing by other health care providers for CPCP Covered Services in the CPCP Tier selected by Contractor.

    b. The Expected External Service Provision Adjustment shall be equal to one minus the following quotient:

        PMPM average paid claims for CPCP Covered Services provided by a provider other than Contractor or Contractor's Pooled Participants if Contractor pooled with other Participants pursuant to **Sections 2.5.A.1 or 2.5.H** of the RFA

        +

        (Any payments made to Contractor's Pooled Participants if Contractor pooled with other Participants pursuant to **Sections 2.5.A.1 or 2.5.H** of the RFA for Contractor's Panel Enrollees pursuant to **Sections 4.1.B.2.d, 4.1.B.2.e, 4.1.B.2.f, or 4.1.B.2.g** of this Contract Addendum)

        All divided by

        (The product of Contractor's Base Rate and Risk Score)

    c. Notwithstanding any other provisions of this Contract Addendum, if Contractor first contracted with EOHHS to be a PCC on or after January 1, 2012, EOHHS will establish Contractor's initial Expected External Service Provision Adjustment at an amount equal to the average Expected External Service Provision Adjustment for Contractor's provider type as listed in **Section 4.1.A.2**. EOHHS shall utilize such initial Expected External Service Provision Adjustment amount for all applicable calculations required by this Contract Addendum until EOHHS has available at least six months of historical data from Contractor's Panel, after which EOHHS shall calculate Contractor's Expected External Service Provision Adjustment pursuant to **Sections 4.1.A.4.a and 4.1.A.4.b**.

5. EOHHS shall calculate Base Rates on an annual basis, and shall calculate Risk Scores and Expected External Service Provision Adjustments on a quarterly basis. Quarterly

calculations shall be based on the most recent consecutive twelve month period of reliable and available claims data.

6. If a Panel Enrollee on Contractor's Panel receives a CPCP Covered Service from a qualified health care provider that is not Contractor or Contractor's Pooled Participant Participants if Contractor pooled with other Participants pursuant to **Sections 2.5.A.1** or **2.5.H** of the RFA, EOHHS shall adjust Contractor's CPCP Rate to reflect that activity.

7. If and at such time that EOHHS implements the "Health Homes" initiative for Members that meet certain Severe and Persistent Mental Illness criteria, if a Panel Enrollee on Contractor's Panel chooses as his or her Health Home a provider other than Contractor or Contractor's Behavioral Health Provider, EOHHS shall decrease Contractor's CPCP Rate to reflect that care management services will be provided by such Health Home provider.

B. EOHHS shall implement, and shall require the BH Vendor to implement, the CPCP in accordance with the following:

1. EOHHS reserves the right to, for the portion of the CPCP Rate that is based on CPCP Covered Services in CPCP Tier 1, and to require the BH Vendor to, for the portion of the CPCP Rate that is based on CPCP Covered Services in CPCP Tier 2 or 3:

   a. Retroactively adjust the CPCP such that Contractor is not paid for Panel Enrollees on Contractor's Panel that meet the following criteria:

      1) Panel Enrollee has been enrolled with Contractor for four months or more; and

      2) Panel Enrollee did not have an in person visit with Contractor or Contractor's Behavioral Health Provider in the prior 18 months. Any such visit shall be demonstrated by EOHHS receipt of a claim for such service during the applicable time period.

2. EOHHS shall, for the portion of the CPCP Rate that is based on CPCP Covered Services in CPCP Tier 1, and EOHHS shall require the BH Vendor to, for the portion of the CPCP Rate that is based on CPCP Covered Services in CPCP Tier 2 or 3:

   a. Pay the CPCP on or about the first business day of each month to Contractor. The CPCP shall be equal to the PMPM CPCP Rate, times the total number of Panel Enrollees enrolled in the PCC Plan and attributed by EOHHS to the Contractor. For each monthly CPCP payment, EOHHS shall determine the number of Panel Enrollees attributed to the Contractor using the most recent and reliable available attribution list, in EOHHS' discretion.

   b. Adjust the CPCP on a quarterly basis as described above as Risk Scores and Expected External Service Provision Adjustments are calculated. On or about 20 days before the start of a new quarter, EOHHS shall share with Contractor the updated CPCP Rate, including the Base Rate, Risk Score, and Expected External Service Provision Adjustment.

c. At the request of Contractor, make corrections to payments, in EOHHS' sole discretion, if an error occurred in the calculation of the CPCP that resulted in an amount not consistent with the methodology.

1) To qualify for a correction, Contractor shall contact EOHHS in writing, within 15 business days of receiving the CPCP, and shall include with its request for a correction all of the necessary documentation that is part of the requested correction to demonstrate that an error has occurred.

2) EOHHS may choose to not consider a request for correction that does not include all necessary documentation.

d. Notwithstanding any other provisions of this Contract Addendum, for services provided under this Contract Addendum from the Operational Start Date to December 31, 2014, if Contractor is not a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), EOHHS shall pay or require the BH Vendor to pay, Contractor in accordance with the following:

1) If the total amount of Contractor's claims for services that were zero-paid pursuant to **Section 3.4.E** of this Contract Addendum plus (25% multiplied by the Medical Home Load, multiplied by Contractor's CPCP Risk Score, multiplied by the total number of Panel Enrollees for whom EOHHS made CPCP payments to the Contractor during the specified period) is greater than the CPCP payments paid during the specific period, EOHHS shall pay, or require the BH Vendor to pay, Contractor the difference between the amounts for each of the following periods, with payment to be made on or after the date that is six months after the end of each applicable period:

a) March 1, 2014 through June 30, 2014;

b) July 1, 2014 through September 30, 2014; and

c) October 1, 2014 through December 31, 2014.

2) For services provided on or after January 1, 2015, Contractor shall not be eligible for any payments under this **Section 4.1.B.2.d**, but shall be eligible for payments under **Section 4.1.B.2.e**.

e. If the Contractor is not a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), for services provided under this Contract Addendum on or after January 1, 2015, if the total amount of Contractor's claims for services that were zero-paid pursuant to **Section 3.4.E** of this Contract Addendum during the specific period exceeds the total CPCP paid during the specific period by more than 10% of the CPCP paid, EOHHS shall pay or shall require the BH Vendor to pay Contractor the amount of the difference in excess of 10% of the total CPCP paid, for each of the following periods, with payment to be made on or after the date that is six months after the end of each applicable period:

1) January 1, 2015 through March 31, 2015; and

2) April 1, 2015 through June 30, 2015; and

3) July 1, 2015 through September 30, 2015; and

4) October 1, 2015 through December 31, 2015; and

5) January 1, 2016 through March 31, 2016; and

6) April 1, 2016 through June 30, 2016; and

7) July 1, 2016 through September 30, 2016; and

8) October 1, 2016 through December 31, 2016.

f. Notwithstanding any other provisions if Contractor is a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), consistent with 42 USC § 1396a(BB), EOHHS shall pay or require the BH Vendor to pay, Contractor in accordance with the following:

For services provided under this Contract Addendum from the Operational Start Date to December 31, 2014, if the total amount of Contractor's claims for services provided under this Contract Addendum that were zero-paid pursuant to **Section 3.4.E** of this Contract Addendum, as specified in 114.3 CMR 4.00, et seq. and excluding any supplemental rate paid by MassHealth to FQHCs or RHCs, plus (25% multiplied by the Medical Home Load, multiplied by Contractor's CPCP Risk Score, multiplied by the total number of CPCP payments EOHHS made to the Contractor during the specified period), is greater than the CPCP paid during the specific period, EOHHS shall pay, or require the BH Vendor to pay, Contractor the difference between the amounts for each of the following periods, with payment to be made on or after the date that is six months after the end of each applicable period:

1) March 1, 2014 through June 30, 2014;

2) July 1, 2014 through September 30, 2014; and

3) October 1, 2014 through December 31, 2014.

g. For services provided under this Contract Addendum on or after January 1, 2015, if the total amount of Contractor's claims for services that were zero-paid pursuant to **Section 3.4.E** of this Contract Addendum as specified in 114.3 CMR 4.00, et seq. and excluding any supplemental rate paid by MassHealth to FQHCs or RHCs, is greater than the CPCP paid during the specific period, EOHHS shall pay, or require the BH Vendor to pay, Contractor the difference between the amounts for each of the following periods, with payment to be made on or after the date that is six months after the end of each applicable period:

1) January 1, 2015 through March 31, 2015; and

2) April 1, 2015 through June 30, 2015; and

3) July 1, 2015 through September 30, 2015; and

4) October 1, 2015 through December 31, 2015; and

5) January 1, 2016 through March 31, 2016; and

6) April 1, 2016 through June 30, 2016; and

7) July 1, 2016 through September 30, 2016; and

8) October 1, 2016 through December 31, 2016.

Section 4.2 Quality Incentive Payments

Contractor may be eligible to receive a Quality Incentive Payment, consistent with **Section 5.3** of the RFA and the following:

A. EOHHS shall determine the list of Quality Measures to be used for purposes of calculating the Quality Incentive Payment, including Pay-for-Reporting (P4R) and Pay-for-Quality (P4Q), and to modify the Shared Savings / Risk Payments. **Attachment A** to this Contract Addendum provides a preliminary list of Quality Measures to be used for such purposes.

1. EOHHS shall determine, prior to the start of each PCPRI program year, which Quality Measures will be used for P4R and P4Q or to modify Shared Savings / Risk Payments.
2. Only Quality Measures reported by Contractor shall be eligible for P4R.
3. In Year 1, all Quality Measures reported by Contractor shall be eligible for P4R and no Quality Measures shall be eligible for P4Q.
4. In Years 2 and 3, EOHHS may opt to assign Quality Measures to P4Q if the prior year has demonstrated that the majority of Contractors are able to accomplish satisfactory reporting.
5. EOHHS reserves the right to amend the list of Quality Measures with 90 days' advance notice to Contractor.

B. In implementing Quality Incentive Payments, EOHHS shall:

1. Calculate the P4R Total Performance Score by determining for each Quality Measure, on a quarterly basis or as otherwise specified by EOHHS, whether Contractor's reporting has been satisfactory as defined by completeness, timeliness and accuracy of the data submitted to EOHHS. EOHHS reserves the right to audit Contractor. The P4R Total Performance Score is equal to the percentage of P4R Quality Measures reported successfully.

2. Determine a plan to improve Contractor's reporting, together with Contractor, if Contractor's reporting is determined by EOHHS to be inadequate. Contractor shall implement such plan as directed by EOHHS.

3. Calculate, for Contractor, on an annual basis or as otherwise specified by EOHHS, an aggregated P4Q Total Performance Score based on performance of the Quality Measures as described in **Section 3.2.F** of this Contract Addendum.

4. Prior to the start of each PCPRI program year, EOHHS shall determine a base payment for P4R and a base payment for P4Q. In Year 1, the base payment for P4R will be equal to 5% of the annual CPCP paid by EOHHS to the Contractor, and there will be no base payment for P4Q as there will be no P4Q measures.

C. EOHHS shall pay Contractor the Quality Incentive Payment as the sum of the following two amounts:

1. Base payment for P4R * P4R Total Performance Score; and

2. Base payment for P4Q * P4Q Total Performance Score.

D. EOHHS may opt to pay the P4R in cases where a Quality Measure was not reported successfully, but Contractor has and adheres to a plan to improve reporting.

E. EOHHS reserves the right, in its sole discretion, to change the methodology for calculating the Quality Incentive Payment.

F. Contractor must comply with the time periods for reporting set forth on **Attachment A** to this Contract Addendum in order to receive a Quality Incentive Payment for either reporting or performance of such Quality Measures.

G. Contractor's achievement of Shared Savings under the Shared Savings / Risk Payment is not a pre-requisite to receive a Quality Incentive Payment.

H. If Contractor has pooled with other Participants or was pooled by EOHHS with other Participants ("Pooled Participants"), the following shall apply:

1. For Pooled Participants, EOHHS shall calculate the P4R and P4Q Total Performance Scores for each group of Pooled Participants

2. EOHHS shall use the P4R and P4Q Total Performance Score calculated at the pool level to calculate each Participant's total Quality Incentive Payment

3. EOHHS shall not be involved with or liable for any activities relating to or consequences resulting from the apportionment of payments between and among the Pooled Participants, and Contractor shall have no cause of action or other claim against EOHHS relating to such apportionment.

Section 4.3 Shared Savings / Risk Payments

To calculate a Shared Savings / Risk Payment as described in **Section 5.4** of the RFA, EOHHS shall:

A. Calculate the Shared Savings / Risk Payment based on the difference between Contractor's Actual Spend and Target Spend across PCC and MCO Panel Enrollees; and based on Contractor's selection of a Risk Track and whether it has included Long-Term Services and Supports (LTSS), as indicated in its Application.

B. Determine whether to modify Contractor's Shared Savings / Risk Payments according to **Section 4.3.G** of this Contract Addendum.

C. Calculate Actual Spend for PCC Panel Enrollees as follows:

1. Actual Spend for PCC Panel Enrollees shall be calculated as the average per Panel Enrollee, per month sum of MassHealth paid amounts on Shared Savings Included Services for the PCC Panel Enrollees on Contractor's Panel in a given year.
2. Shared Savings Included Services consist of all MassHealth covered services except:

    a. CPCP Covered Services;

    b. Long-Term Services and Supports (LTSS), if Contractor selects the option that excludes LTSS from Shared Savings / Risk Payments as indicated in its Application; and

    c. For services received by a member whose total claims for the year exceed $145,000, while attributed to the Contractor, 90% of all dollars in excess of $145,000.

3. If Contractor selects the option to include LTSS, all Shared Savings Payments to the Contractor will be increased by 10%.
4. The following types of payments shall not be considered expenditures on MassHealth covered services:

    a. Non-covered services, such as, for example, Panel Enrollees in a nursing facility for other than a short-term rehabilitation stay;

    b. Non-Fee-For-Service claims-based incentive payments;

    c. Management fees;

    d. Infrastructure payments (e.g., medical home supplemental payments);

    e. Dental claims except for those limited services that are covered by health care coverage premium payments, and

    f. Risk contract settlements (including prior year PCMHI Shared Savings / Risk Payments).

D. Calculating Target Spend for PCC Panel Enrollees

Target Spend for PCC Panel Enrollees shall be based on calculating the weighted average of Actual Spend for PCC Panel Enrollees in the most recent eight consecutive quarters of available and reliable data, with the weighting of two-thirds weight on the more recent year's data and one-third weight on the less recent year's data, and trending that forward. Beginning on October 1, 2014, EOHHS will update Contractor's Target Spend every six months. Trending forward shall involve:

1. Adjusting for changes in the relevant features of Contractor's Panel including age, sex and diagnoses, changes in population size, and changes in DXCG risk score;
2. Applying a growth rate. The growth rate shall be equal to the observed growth rate in Actual Spend for the PCC and MCO managed care population (including Panel Enrollees enrolled with Contractor, Panel Enrollees enrolled with other Participants, and Panel Enrollees not enrolled with Participants), based on the most recent available data; and
3. To the extent that EOHHS alters payment rates or methodologies for services, accounting for these changes in the Target Spend for PCC Panel Enrollees.

E. Risk Tracks

1. Contractor shall comply with the requirements applicable to the Risk Track indicated in its Application for the term of this Contract Addendum, except as provided below.
2. Contractor shall change its Risk Track in accordance with the following:

    a. Contractor may only change its Risk Track prior to the start of each Year of this Contract Addendum and only with the prior approval of EOHHS.

    b. For Year 1, Contractor is not permitted to switch Risk Tracks.

    c. Unless EOHHS determines otherwise for good cause, for Year 2, if Contractor selected Risk Track 3 (Upside Only) in its Application, the Contractor shall switch to Risk Track 1 or 2 by providing a written request to EOHHS and may not switch back to Risk Track 3 for the remaining term of the Contract Addendum

        1) By July 1, 2014, Contractor shall submit to EOHHS either (1) documentation that Contractor has applied for DOI certification as described in **Section 3.5** of this Contract Addendum or (2) a petition for exemption for good cause from the requirement to switch Risk Tracks.

        2) No later than 90 days prior to the start of Year 2, the Contractor shall provide EOHHS with evidence that the Contractor is able to manage Downside Risk associated with either Risk Track 1 or 2 as required by **Section 2.7** of the RFA.

        3) EOHHS shall determine whether the Contractor has demonstrated it has the ability to manage the Downside Risk associated with Risk Track 1 or 2, as selected by the Contractor, and shall notify Contractor of its determination no later than 45 days before the start of Year 2.

4) If the Contractor does not do so prior to 90 days before the start of Year 2, EOHHS may select the Risk Track for the Contractor.

3. EOHHS further reserves the right to change Contractor's Risk Track, in the event that a Contractor no longer meets the criteria for participating in a given Risk Track.

F. Administration of Shared Savings / Risk Payments

1. EOHHS shall determine whether to modify Participant's risk track in accordance with **Section 4.3.E**, and assess and pay the Shared Savings / Risk Payments on an annual basis, on or about twelve months after the last day of the applicable annual period. For example, for Year 1, EOHHS shall pay Contractor any applicable Shared Savings / Risk Payments on or about December 2015.
2. If Contractor is in Risk Track 1 or Risk Track 2 (Downside Risk options) and EOHHS has determined that Contractor owes any Shared Losses to EOHHS, Contractor shall repay such Shared Losses annually.
3. If Contractor fails to repay any Shared Losses determined by EOHHS within the required timeframe, EOHHS may deduct the amount owed from Contractor's CPCP payments.
4. EOHHS shall pay Contractor annually a portion of the total calculated Shared Savings / Risk payment equal to EOHHS' share of all payers' total savings for that year for the Contractor's Panel Enrollees.

G. Modification of Shared Savings / Risk Payments Due to Quality Performance

1. Starting in Year 1, EOHHS may opt to use Quality Measures to modify Shared Savings / Risk Payments, as follows:

   a. Any Shared Savings / Risk Payment that Contractor is eligible for as Shared Savings will be equal to the payment described in this **Section 4.3** multiplied by 1, 0.8, 0.6, or 0 depending on whether the Shared Savings / Risk Performance Score is categorized as Excellent, Good, Fair, or Poor, respectively.

   b. Any Shared Savings / Risk Payment that Contractor owes to EOHHS as Shared Losses will be equal to the payment described in this **Section 4.3** multiplied by 0.6, 0.8, 1, or 1, depending on whether the Shared Savings / Risk Performance Score is categorized as Excellent, Good, Fair, or Poor, respectively.

2. The calculation of the Shared Savings / Risk Performance Scores and the assignment of the Shared Savings / Risk Performance Scores to each category shall be as set forth in **Section 3.2.G** of this Contract Addendum.

H. Payment to Pooled Participants

If Contractor has pooled with other Participants or was pooled by EOHHS with other Participants ("Pooled Participants"), the following shall apply:

1. For Pooled Participants, EOHHS shall calculate the Shared Savings / Risk Payment for each group of Pooled Participants, and the portion that EOHHS is responsible for paying

as described in **Section 4.3.F.4** of this Contract Addendum, and shall pay a pro rata share of the resulting amount to each Participant. For these purposes, a pro rata share is each Participant's share of Panel Enrollee months as weighted by Panel Enrollee enrollment with that Participant over the course of the applicable program year.

2. EOHHS shall not be involved with or liable for any activities relating to or consequences resulting from the apportionment of payments between and among the Pooled Participants, and Contractor shall have no cause of action or other claim against EOHHS relating to such apportionment.
3. If a Pooled Participant fails to repay EOHHS any amount owed under the Shared Savings / Risk Payment, EOHHS may deduct the amount owed from Contractor's CPCP payments.

I. Payment to PCMHI Participants

If Contractor is participating in the PCMHI as of the Operational Start Date of this Contract Addendum, EOHHS shall pay Contractor in accordance with this Contract Addendum as of the Operational Start Date; provided further, that the execution of this Contract Addendum shall terminate Contractor's PCMHI contract addendum, except for the provisions of **Section 3.10** of the PCMHI contract addendum, which shall continue in full force and effect..

SECTION 5. INTERMEDIATE SANCTIONS

In the event that EOHHS determines that Contractor has breached this Contract Addendum or has otherwise violated applicable laws or regulations, EOHHS may take any of the following actions:

A. Provide Contractor with a warning with and an opportunity to cure by adhering to an EOHHS-approved plan of corrective action;

B. Impose sanctions;

C. Withhold some or all payments to Contractor described in **Section 4** to this Contract Addendum;

D. Terminate this Contract Addendum in accordance with the provisions of **Section 6** of this Contract Addendum;

E. Notify any Pooled Participants of Contractor's corrective action requirements; or

F. EOHHS may take any additional actions as specified in this Contract Addendum, the PCC Contract, the RFA, and as otherwise permitted in law or regulation, not otherwise specified above.

EOHHS shall give notice to Contractor specifying all such breaches or violations. No provision in this Contract Addendum shall be construed to limit the generality of this **Section 5** of this Contract Addendum (Intermediate Sanctions).

Notwithstanding any other available remedy, EOHHS reserves the right to withhold the Shared Savings Payments, in part or in full, for any material violations of the provisions of this Contract Addendum, including without limitation **Section 3.4.C, 3.4.D.3.d., or 3.4.K**.

SECTION 6. TERM AND TERMINATION

This Contract Addendum shall be effective as of the Effective Date and through December 31, 2016. At the option of Payer, this Contract Addendum may be extended for up to five additional years.

Section 6.1 Termination for Cause

EOHHS may terminate this Contract Addendum for cause prior to the end of its term, with 30 days' notice, if:

A. Contractor fails to meet any of the qualifying criteria set forth in **Section 2** of this Contract Addendum;

B. Contractor withdraws from or is terminated from the PCC Plan or the MassHealth program;

C. EOHHS determines that a change in the structure of Contractor has resulted in Contractor's being substantially different than as described within Contractor's Response to participate in the PCPRI; or

D. EOHHS determines that Contractor has not complied with the requirements set forth in this Contract Addendum.

E. As of the first day of Year 2 of this Contract Addendum, the Contractor fails to meet the qualifications to be a Risk Tracks 1 or 2 PCPRI Participant and to execute any and all amendments to the PCPRI Contract required to participate as such.

Termination of this Contract Addendum shall not operate to terminate Contractor's PCC Plan Provider Contract, except as otherwise indicated herein.

Notwithstanding the foregoing, if EOHHS determines that the continued participation of Contractor may endanger the health, safety, or welfare of Members, EOHHS, without prior notice or hearing, may immediately suspend Contractor from participation in the MassHealth program, including but not limited to the PCPRI, and take other appropriate administrative actions against Contractor. In such event, EOHHS shall notify Contractor in writing of the reasons for the immediate suspension and of applicable appeal rights available to Contractor.

Section 6.2 Termination Without Cause

Either party may terminate this Contract Addendum without cause with 60 days' prior written notice to the other party.

Section 6.3 Termination by Contractor

Upon breach of this Contract Addendum by EOHHS, Contractor may terminate this Contract Addendum upon 30 days' prior written notice to EOHHS.

SECTION 7. EOHHS RESPONSIBILITIES

EOHHS shall:

A. Subject to compliance with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA), periodically provide Contractor with a list of its Panel Enrollees who EOHHS believes may be Higher Risk Panel Enrollees.

B. Share certain data with Contractor as described in **Section 6.3** of the RFA.

C. Provide other appropriate data that EOHHS determines may be helpful and/or that Contractor requests, including summary measures of inpatient and outpatient service utilization and related costs incurred by Contractor's Panel Enrollees.

D. Upon request by Contractor, EOHHS may provide the data described in this **Section 7** to Contractor's identified business associate, provided that:

   1. Contractor shall have a HIPAA-compliant business associate agreement with such identified business associate; and
   2. Contractor and its identified business associate shall comply with all applicable federal and state privacy and security laws and regulations.

SECTION 8. ADDITIONAL TERMS AND CONDITIONS

A. This Contract Addendum is subject to approval by the Centers for Medicare and Medicaid Services (CMS), and EOHHS may revise or eliminate any provision of the Contract Addendum that CMS does not approve.

B. Contractor understands and agrees that: (1) it submitted a Response to EOHHS' Request for Applications for the PCPRI; (2) the Primary Care Payment Reform Initiative (PCPRI) is an EOHHS initiative; (3) EOHHS's sole obligations to Contractor are to provide payment to Contractor for services to Panel Enrollees as described in this Contract Addendum, subject to all of the terms and conditions stated herein, and to provide certain data and technical assistance to Contractor.

C. Contractor understands and agrees that if it enters into agreements with any other Participants who are participating in the PCPRI, it shall not have any standing or right to maintain any action at law or equity against EOHHS or any EOHHS agency under such agreements for any reason including the failure of another Participant to pay Contractor in whole or in part, any amount that is disputed for any reason.

D. Contractor agrees and understands that, if Contractor has an executed contract with EOHHS to participate in the PCMHI, the execution of this Contract Addendum shall operate to terminate Contractor's contract with EOHHS for the PCMHI, except that Contractor shall continue to provide information to EOHHS for purposes of evaluating the PCMHI.

E. EOHHS shall have the option at its sole discretion to modify, increase, reduce or terminate any activity related to this Contract Addendum whenever, in the judgment of EOHHS, the goals of the program have been modified or altered in a way that necessitates such changes. In the event that the scope of work or portion thereof must be changed, EOHHS shall provide written notice of such action to Contractor and the parties shall negotiate in good faith to implement any such changes proposed by EOHHS and, as determined appropriate by EOHHS, may result in an adjustment to Contractor's CPCP Rate or result in EOHHS reimbursing Contractor for the costs of implementing such new initiatives.

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

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

1. New MassHealth programs, or expansion of or changes to existing MassHealth programs;
2. Other programs as specified by EOHHS;
3. Programs resulting from state or federal legislation, including but not limited to the Patient Protection and Affordable Care Act (ACA) of 2010, Chapter 224 of the Acts of 2012, and regulations, initiatives, or judicial decisions that may affect in whole or in part EOHHS or this Contract Addendum;
4. Changes to EOHHS policies and analysis related to Alternative Payment Methodologies;
5. Health Policy Commission regulations or other guidance regarding PCMH and/or accountable care organization certification;
6. Division of Insurance regulations or other guidance regarding risk certification.

H. After the Effective Date, Contractor may not withdraw any Participating Practice Sites approved by EOHHS from participating in the PCPRI for the term of the Contract Addendum; provided, however, that Contractor may terminate its participation for all of its Participating Practice Sites consistent with the termination provisions of **Section 6** of this Contract Addendum. For Years 2 or 3, a Participant may apply to EOHHS for one or more additional Practice Sites to participate in the PCPRI by submitting such request to EOHHS in writing no later than 60 days before the first day of Year 2 or 3, respectively.

I. For Years 2 or 3, Contractor may:

1. Change the group of Pooled Participants with whom it elected to pool the number of Panel Enrollees on its Panel with other Participants' Panels, as indicated in Contractor's Response. To make this election, Contractor and all other Pooled Participants with whom it wishes to pool for Years 2 or 3 each shall submit a new, complete Response to the RFA and any other information required by EOHHS no later than 60 days before the first day of Year 2 or 3, respectively. EOHHS shall approve such election only if Contractor and its Pooled Participants (i) choose the same Risk Track; (ii) meet the minimum numbers of Panel Enrollees as listed in **Section 2.5.B** of the RFA; and (iii) meet all other applicable requirements of the RFA; or
2. Elect to withdraw from the group of Pooled Participants with whom it elected to pool the number of Panel Enrollees on its Panel with other Participants' Panels, as indicated in Contractor's Response. To make this election, Contractor shall submit a new, complete Response to the RFA and any other information required by EOHHS no later than 60 days before the first day of Year 2 or 3, respectively. EOHHS shall approve such election only if Contractor meets all applicable requirements of the RFA.

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

In Witness Thereof, the parties have executed this Contract Addendum to the Fourth Amended and Restated PCC Plan Provider Contract as of the day and year stated below:

For the Executive Office of Health and Human Services:	**For the Contractor:**
By:_____	By:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

ATTACHMENT A
QUALITY MEASURES

Table A1: Measures for Comprehensive Primary Care Payment Reform

#	NQF #	Measure Name	Measure Steward	Data Collection Options	Data Submission Requirements	Payment		
						Yr 1	Yr 2	Yr 3
Adult Prevention and Screening								
1	421	Adult weight screening and follow up	CMS	Medical record OR Claims with CPT II codes	EOHHS Data Portal (Medical record) or EOHHS to calculate (CPT II codes)	P4R	P4R	P4Q[1]
2	28	Tobacco use assessment and tobacco cessation intervention	CMS	Medical record OR Claims with CPT II codes	EOHHS Data Portal (Medical record) or EOHHS to calculate (CPT II codes)	P4R	P4R	P4Q
3	33	Chlamydia screening	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
4	32	Cervical cancer screening	NCQA (HEDIS)	Claims	None – EOHHS to calculate	SS	SS	SS
5	31	Mammography screening	NCQA (HEDIS)	Claims	None – EOHHS to calculate	SS	SS	SS
Behavioral Health (Adult and Pediatric)								
6	418	Depression screening	CMS	Medical record Claims with CPT II codes	EOHHS Data Portal (Medical record) or EOHHS to calculate (CPT II codes)	P4R	P4R	P4Q
7	4	Initiation and engagement of alcohol/drug dependence treatment	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
8	576	Follow up after hospitalization for mental illness (includes children	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q

#	NQF #	Measure Name	Measure Steward	Data Collection Options	Data Submission Requirements	Payment		
						Yr 1	Yr 2	Yr 3
		and adults)						
9	108	ADHD medication management for children	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
Pediatric Health (Excluding Behavioral Health Measures)								
10	36	Asthma medication	NCQA (HEDIS)	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
11	24	BMI assessment and counseling	NCQA (HEDIS)	Medical record Claims with CPT II codes and G codes	EOHHS Data Portal (Medical record) or EOHHS to calculate (CPT II codes)	P4R	P4R	P4Q
12	1506	Adolescent immunization	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
13	1448	Developmental screening in first three years	CAMHI	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
14	1392	Well child visits: <15 months,	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
15	1516	Well child visits: 3-6 years	NCQA (HEDIS)	Claims	EOHHS to calculate for claims based measures	SS	SS	SS
16		Adolescent well visits	NCQA (HEDIS)	Claims	EOHHS to calculate for claims based measures	N/A	P4Q	P4Q
17	38	Childhood immunizations	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
Adult Chronic Conditions								
18	731	Diabetes composite	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
19	18	Hypertension: Controlling high blood pressure	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q
Access (Adult and Pediatric)								
20	6	CAHPS	AHRQ	Survey	None	N/A	N/A	P4Q
21		Ambulatory Sensitive Emergency Department Visits	Mercer	Claims	None – EOHHS to calculate	N/A	N/A	P4Q
Care Coordination (Adult and Pediatric)								
22	6	CAHPS	AHRQ	Survey	None	N/A	N/A	P4Q
23	97	Medication reconciliation (all	NCQA (HEDIS)	Medical record	EOHHS Data Portal	P4R	P4R	P4Q

#	NQF #	Measure Name	Measure Steward	Data Collection Options	Data Submission Requirements	Payment		
						Yr 1	Yr 2	Yr 3
		patients, regardless of age)						

N/A: Not applicable
P4R: Pay for reporting
P4Q: Pay for quality performance
SS: Shared Savings

Table A2: Timeframes for Quality Measures

CY 2012	September 2013	Baseline for measures used in P4Q based on 2014 performance period. .
CY 2013	September 2014	Used in P4R. Baseline for measures used in P4Q based on 2015 performance period but not also used in P4Q based on 2014 performance period. Combined with data from CY 2012 to create baseline for measures used in P4Q or SS based on 2015 performance period and also used in P4Q based on 2014 performance period. *Participants are required to submit this data for the full year as a condition of participation*
CY 2014	September 2015	Used in P4R and P4Q
CY 2015	September 2016	Used in P4R, P4Q, and SS

CY: Calendar year
P4R: Pay for reporting
P4Q: Pay for quality performance
SS: Shared Savings

Note: In the first year of pay-for-quality or pay-for-reporting, the baseline measure value for a Participant will be based on one year of data. In subsequent years, the baseline measure value will be based on two years of data.